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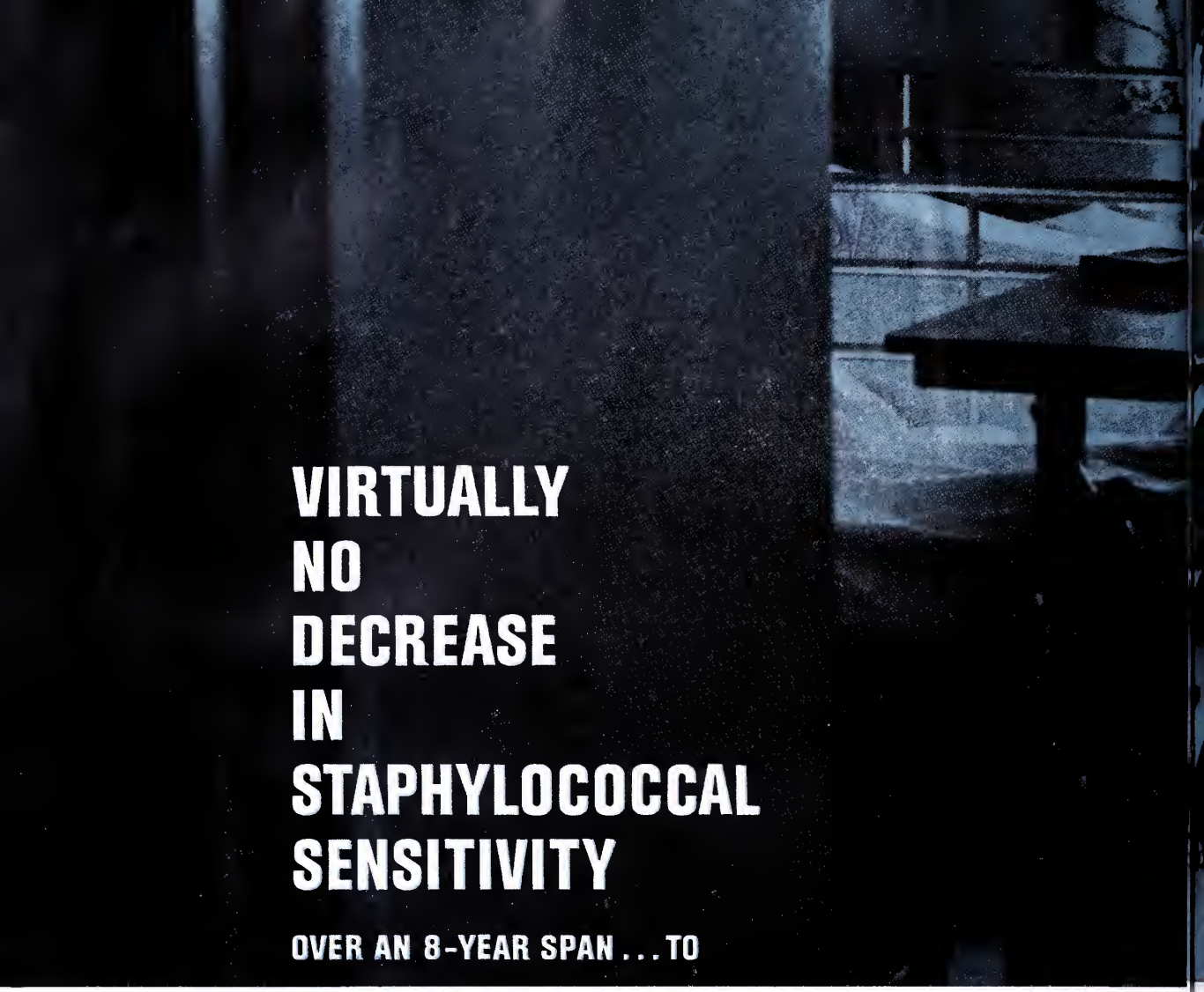
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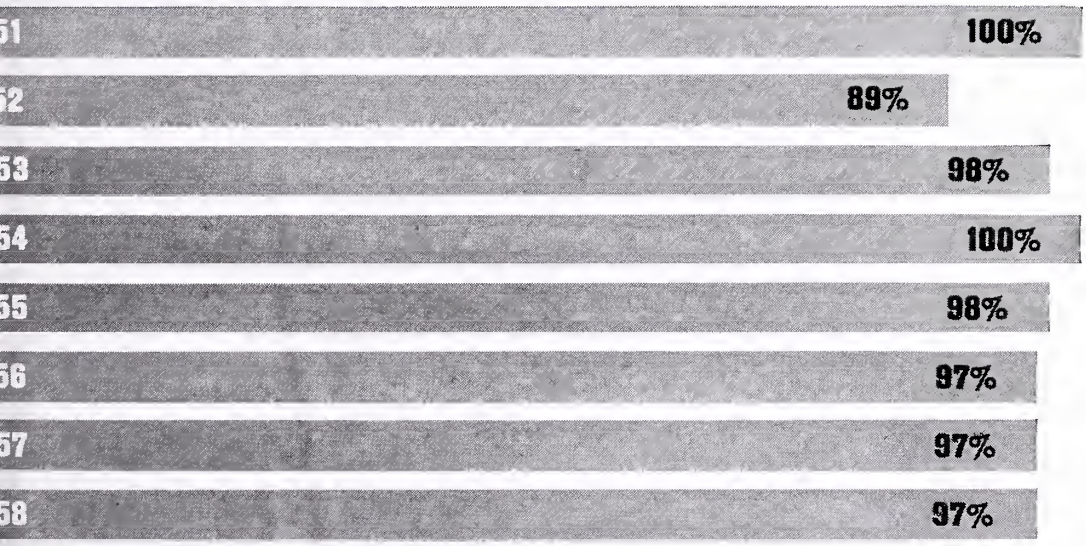
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References: (1) Welch, H., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New Yor Medical Encyclopedia, Inc., 1959, p. 1. (2) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* **82**:513, 1960. (3) Fishe M. W.: *Arch. Int. Med.* **105**:413, 1960. (4) Finland, M., in Welch, H., & Finland, M.: Antibiotic Therapy for Staph lococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 187. (5) Bercovitz, Z. T.: *Geriatrics* **15**:164, 196 (6) Glas, W. W., & Britt, E. M.: Management of Hospital Injections, in Symposium on Antibacterial Therapy, Michiga & Wayne County Acad. Gen. Pract., Detroit, September 12, 1959, p. 7. (7) Staphylococcal Infections in Pediatric Scientific Exhibit, Commission on Professional and Hospital Activities, 108th Ann. Meet., A. M. A., Atlantic Cit June 8-12, 1959. (8) Robinson, H. M., Jr.; Robinson, R. C. V., & Raskin, J.: *Postgrad. Med.* **27**:522, 1960.



SENSITIVITY OF PYOGENIC STRAINS OF STAPHYLOCOCCI TO CHLOROMYCETIN OVER A PERIOD OF EIGHT YEARS*



were gathered over almost a decade on 329 children with staphylococcal pneumonia; 1,663 sensitivity tests were performed.

om Rebhan & Edwards.[2]

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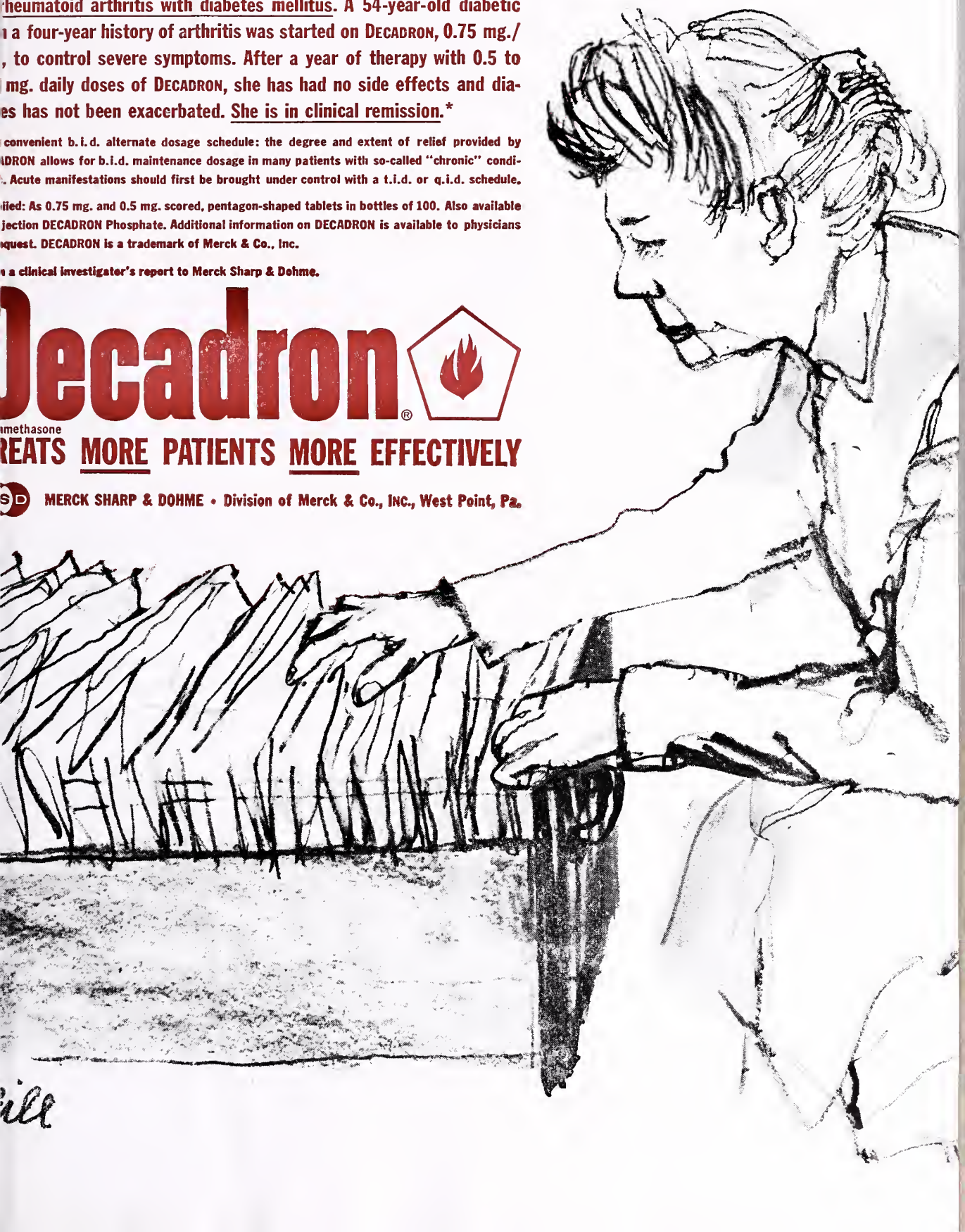
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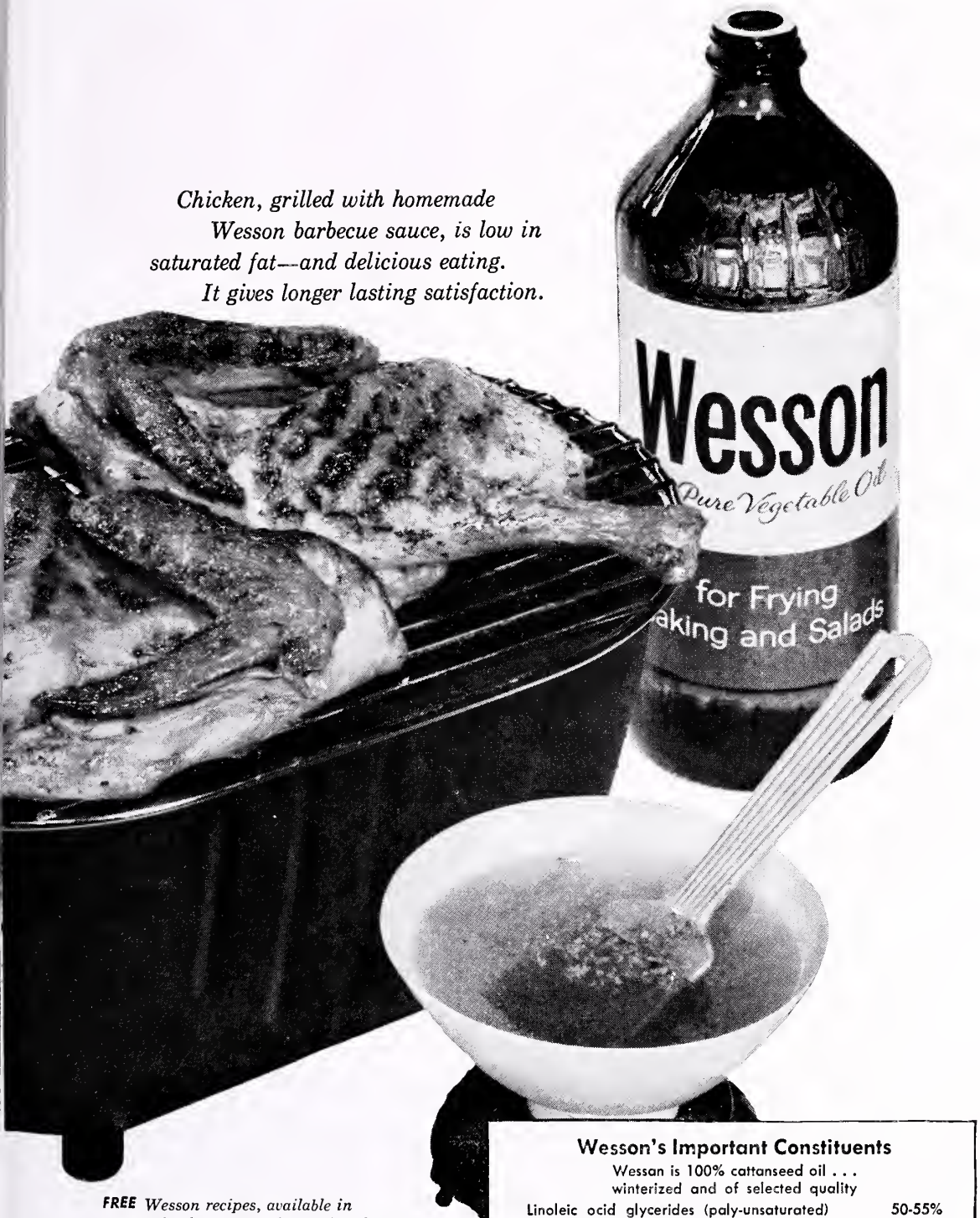


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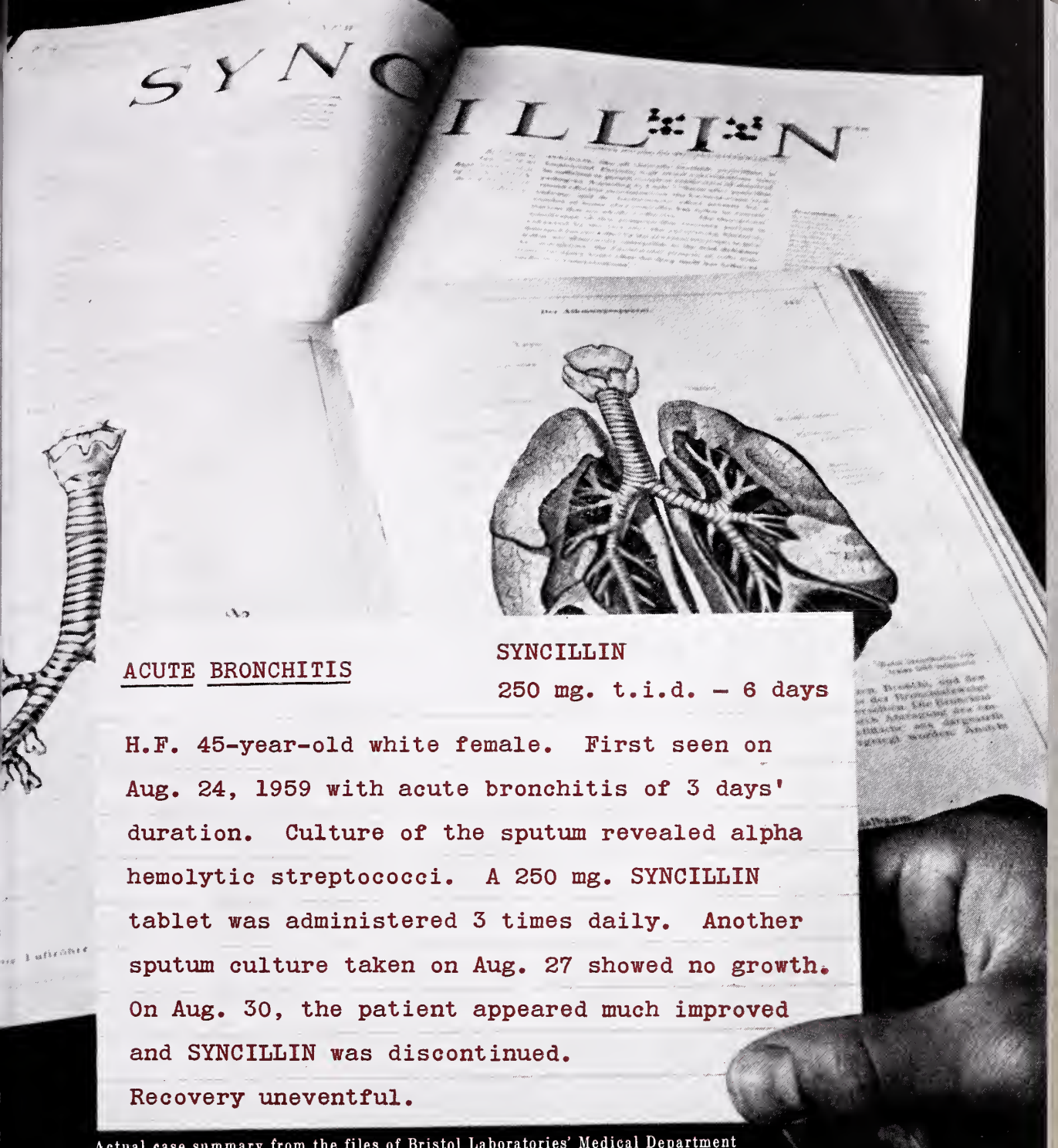


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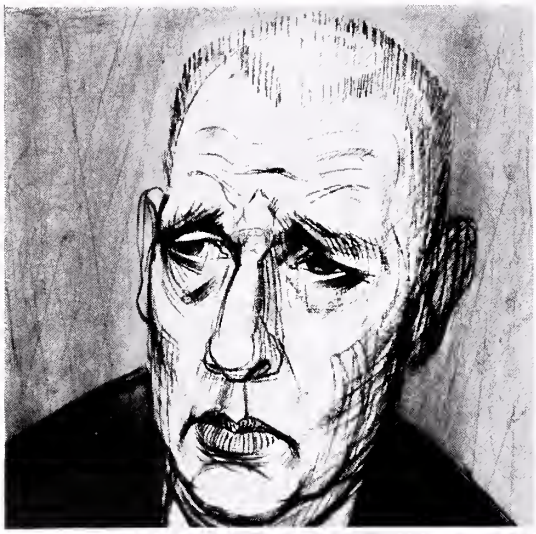
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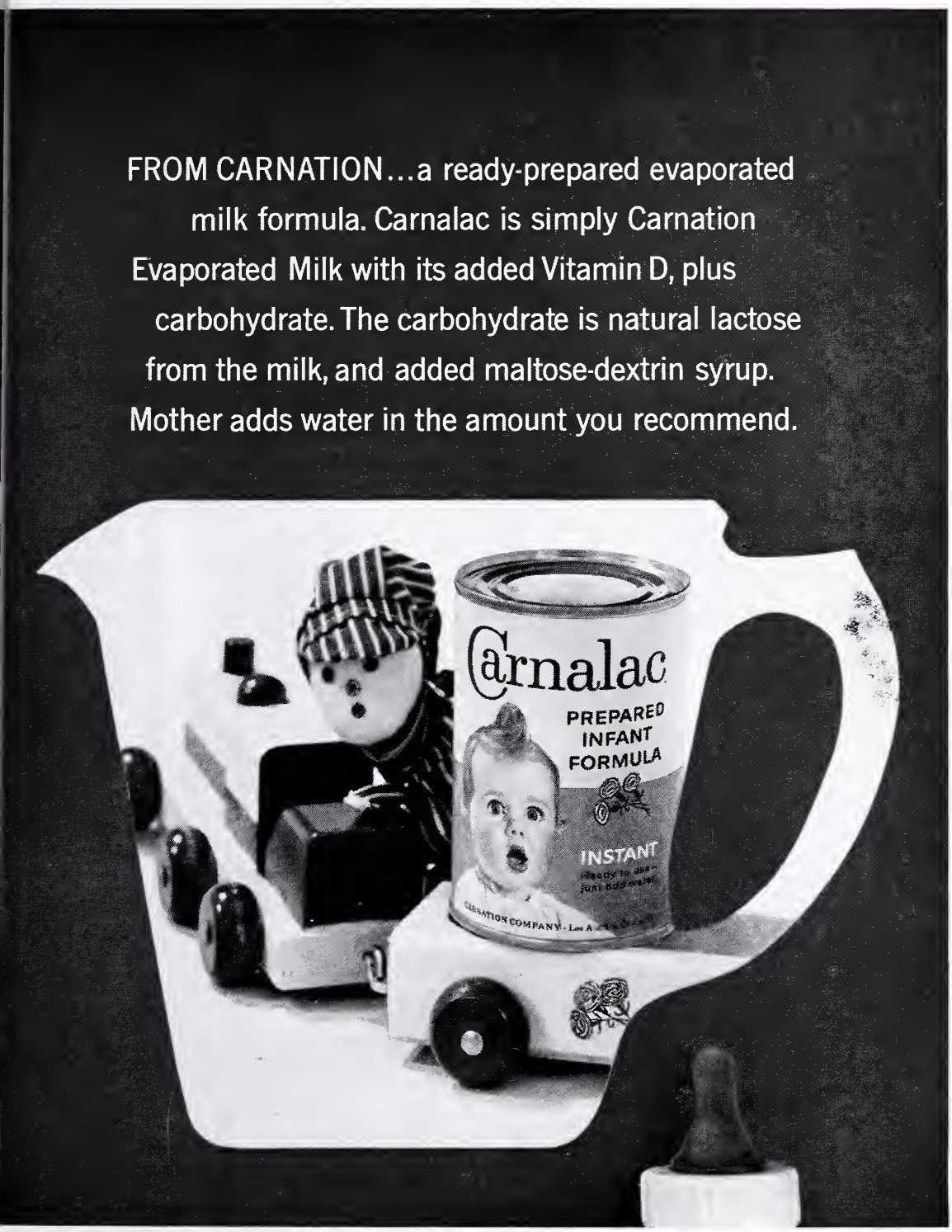
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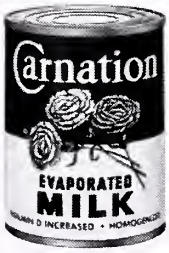
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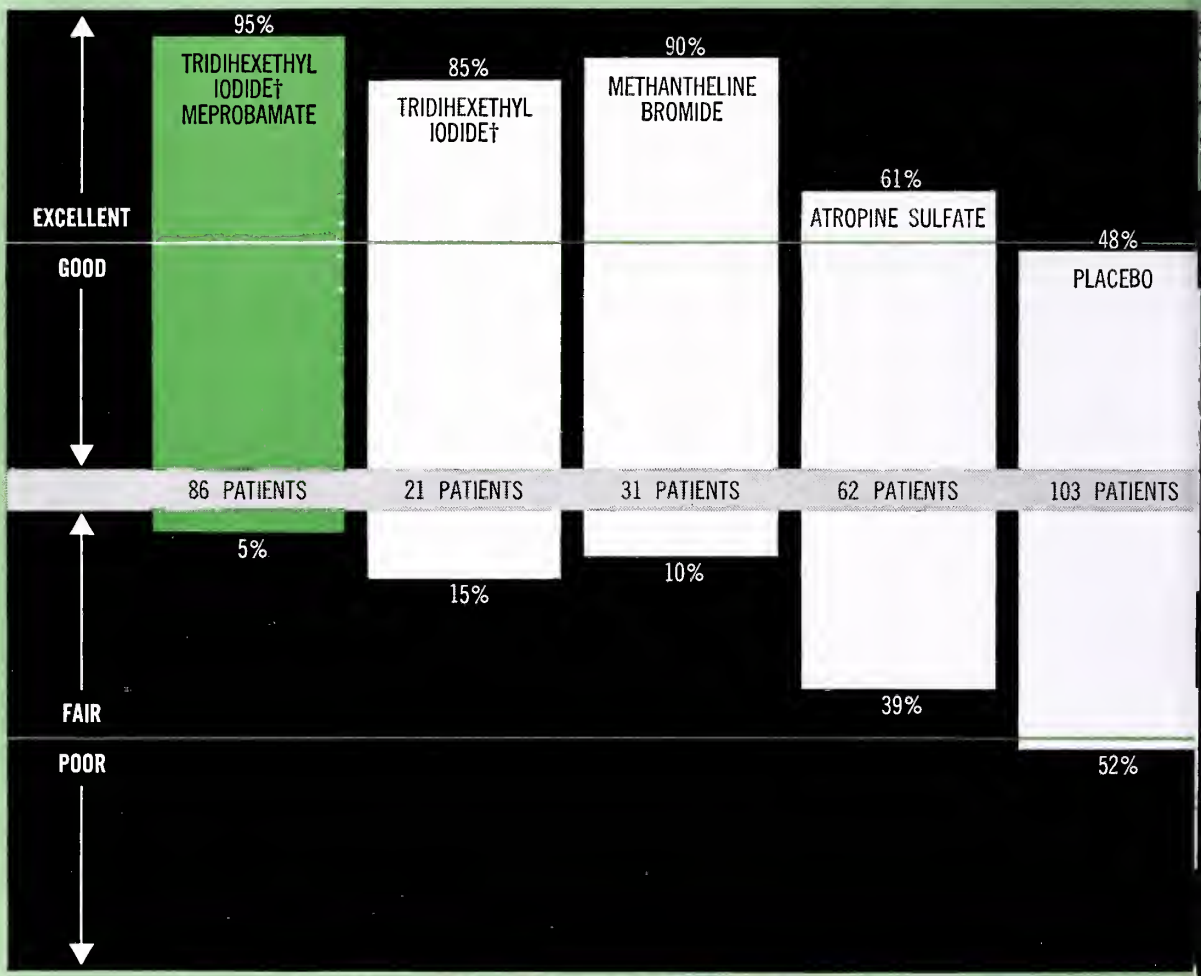
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VISUAL DISTURBANCES	0%	0%	50%	34%	1%
URINARY RETENTION	0%	0%	18%	11%	1%
DROWSINESS	20%	0%	0%	0%	0%
COMPLICATIONS OR SURGERY					
HEMORRHAGE	0%	9%	3%	9%	10%
PERFORATION	0%	0%	0%	6%	0%
OPERATION	0%	5%	5%	14%	2%
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ter, J. S., and Carson, J. M.: Therapeutic Principles in Management of Peptic Ulcer. **Am. J. Digest. Dis.** 4:1055 (Dec.) 1959.

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*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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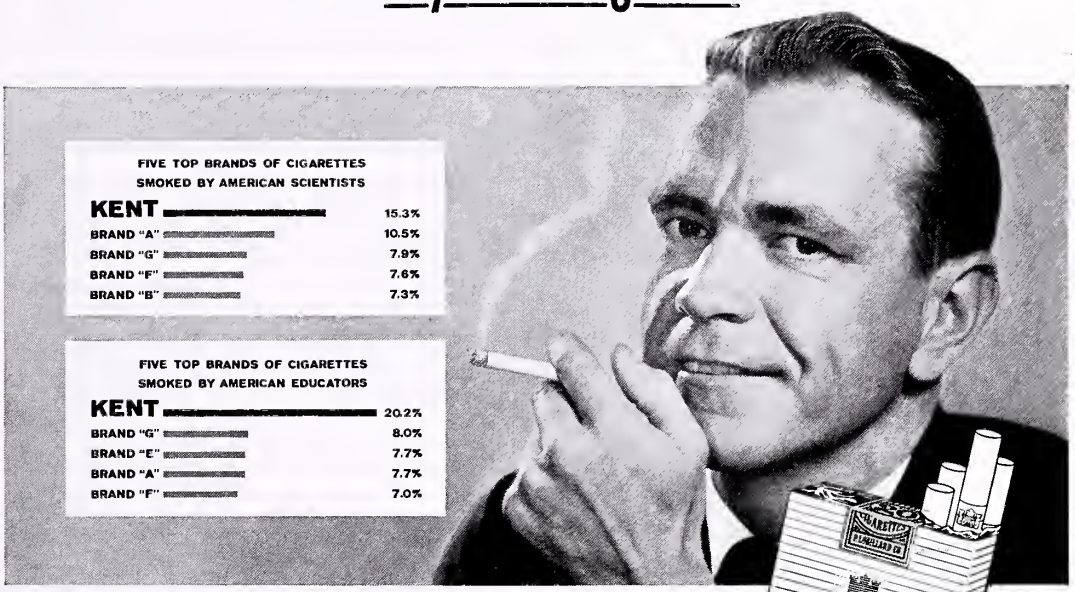
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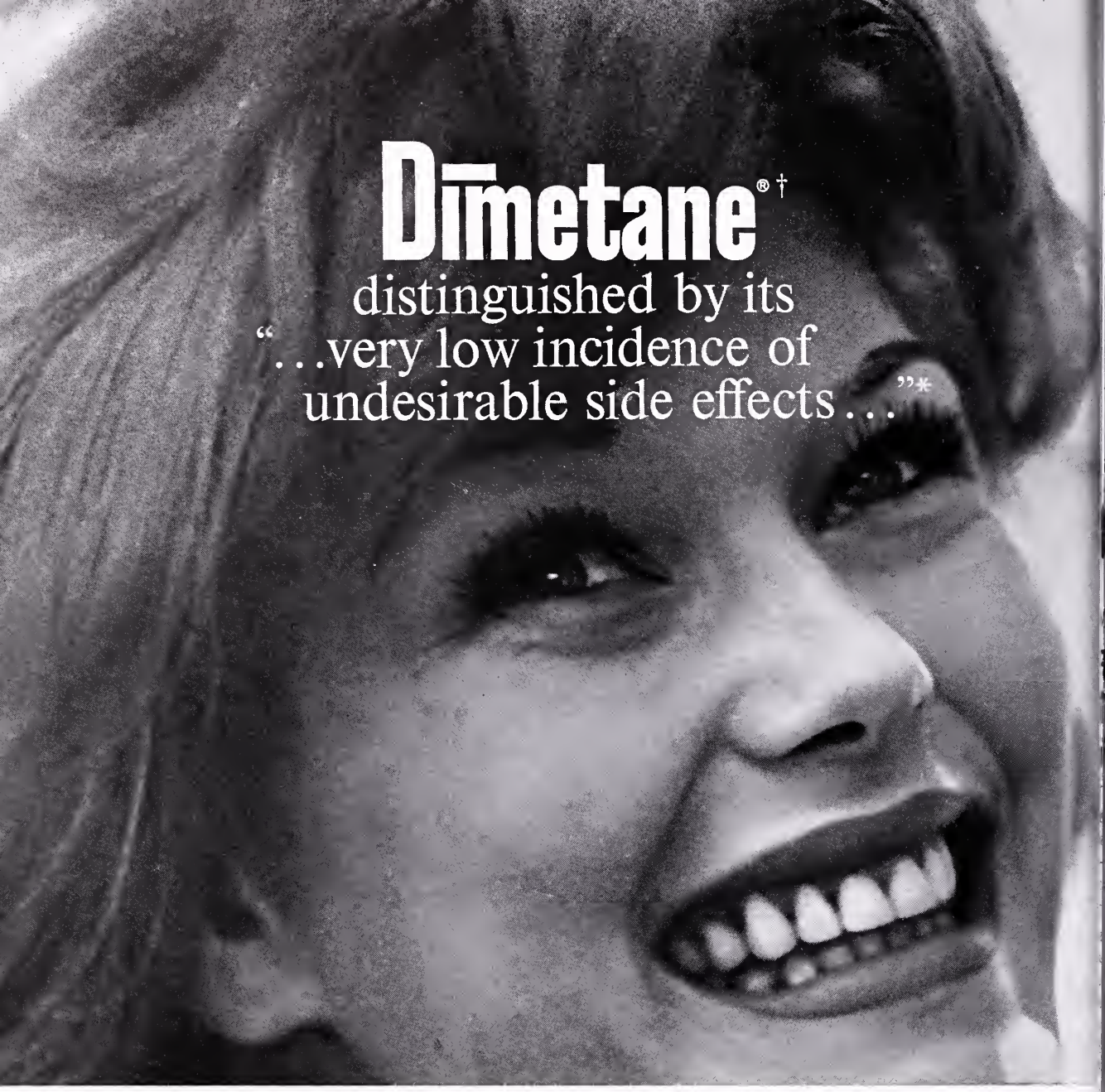
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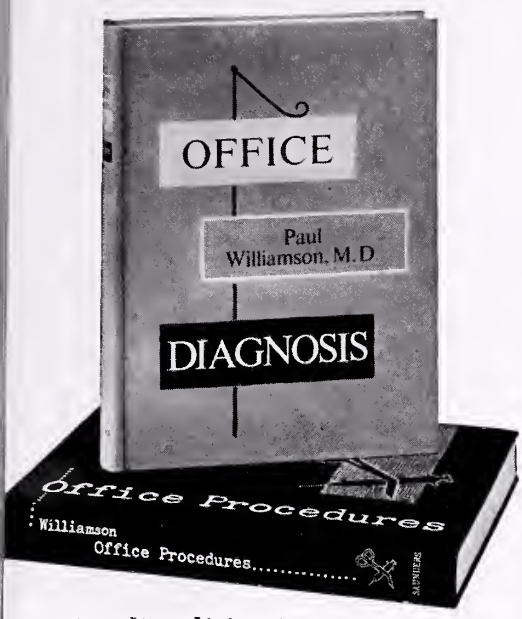
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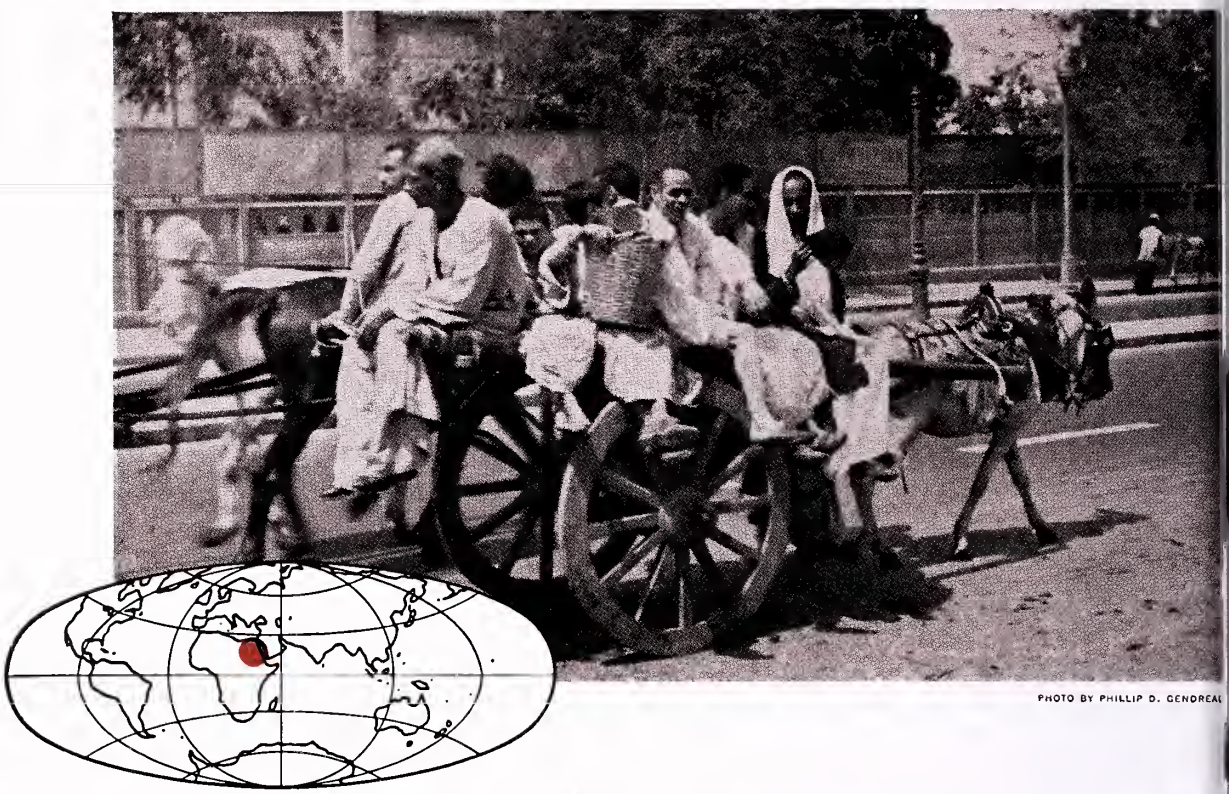


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Musgrave, M. E., and Arm, H. G.: Antibiotic Med. & Clin. Therapy 7:17 (Jan.) 196

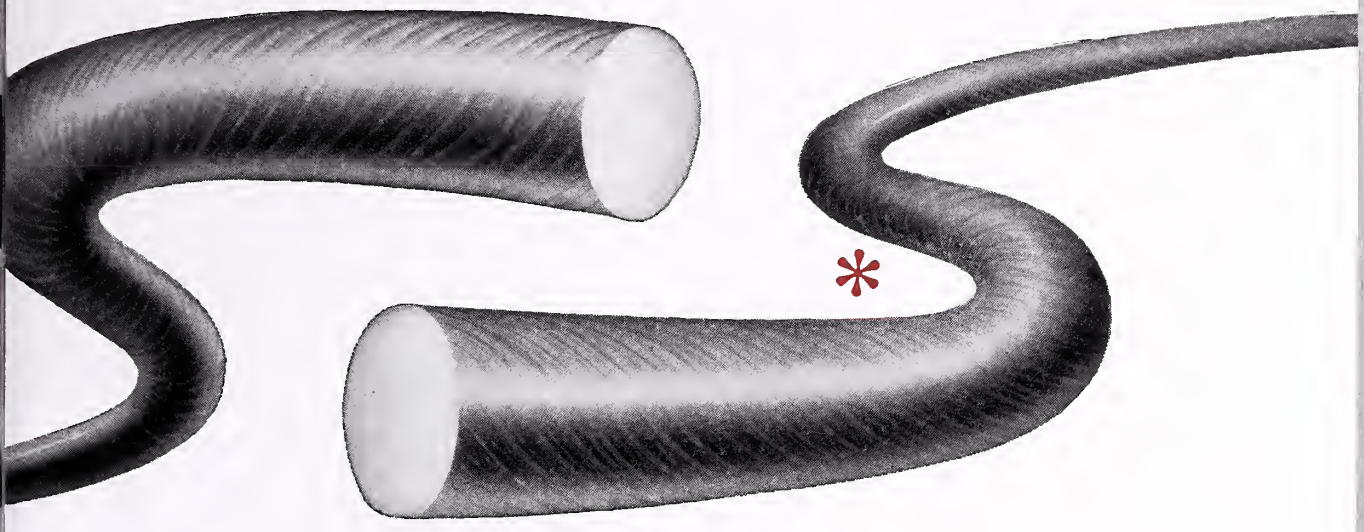
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SUMMIT, N. J.

*Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955. /2830M8

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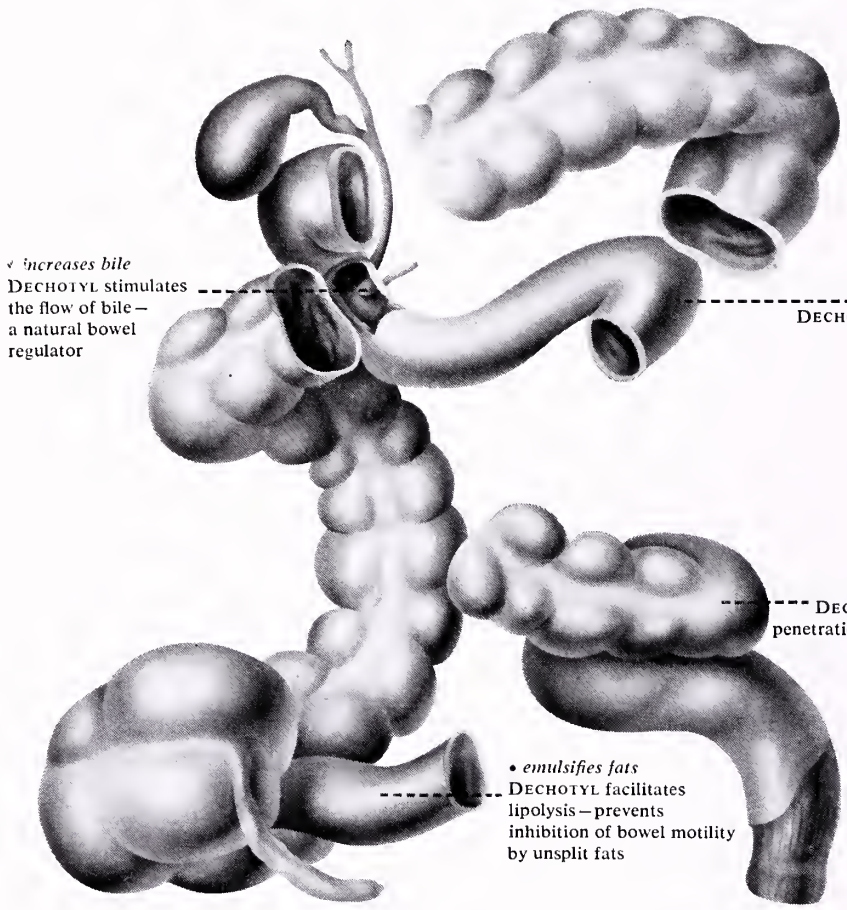
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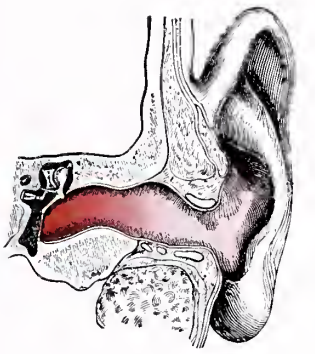
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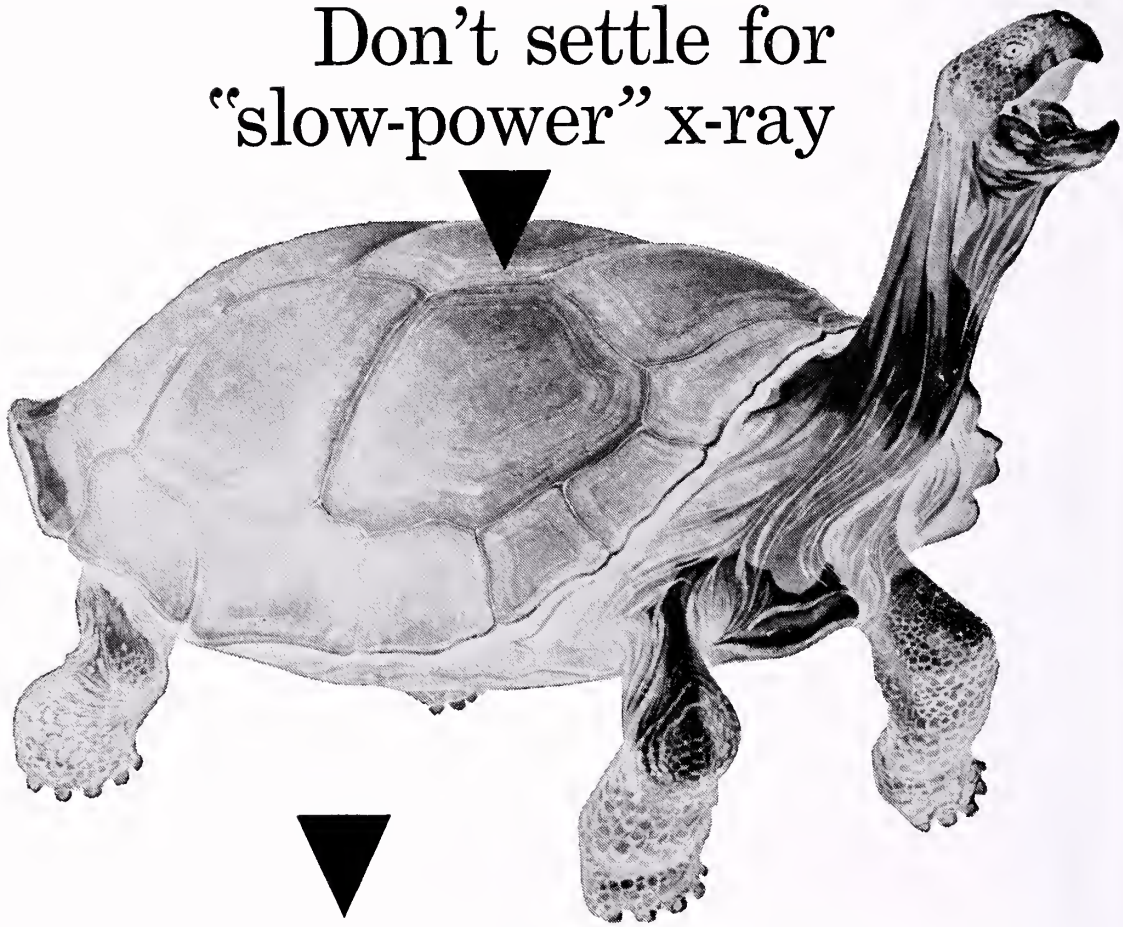
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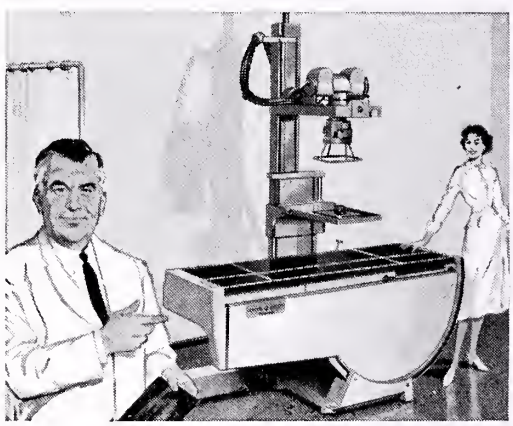
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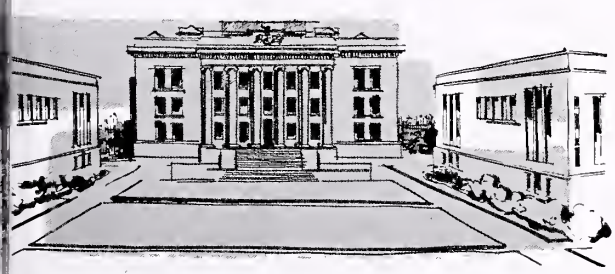
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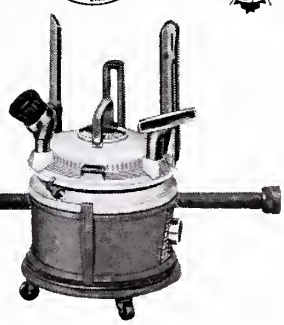
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1. Griffith, R. S.: Comparison of Antibiotic Activity in Sera Following the Administration of Three Different Penicillins, Antibiotic Med. & Clin. Therapy, 7:No. 2 (February), 1960.

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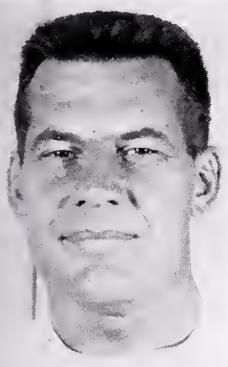
An insurance executive, a sociologist, a hospital administrator, a public health man, and a Social Welfare Department head present their various views of the medical and social problems of aging.

Medico-Socio-Economic Problems of Aging

Panel Discussion

Moderator: FRED I. GILBERT, Jr., M.D., Honolulu

THE HAWAII Medical Association has long concerned itself with the problems of the ged. Ten years ago, its first Committee on Chronic Illness and Aging, headed by Dr. Shoyei Yamauchi, recommended to the Association that a Governor's Commission on Aging be appointed and that this commission, in addition to representatives from the medical profession, include people from the paramedical and nonmedical fields. We appreciated that in addition to the trictly medical problems associated with aging, here were financial, housing, and various social eeds that had to be taken into consideration. Although we are a young state with youthful citizens, we are concerned enough about the aging process to devote this entire annual meeting of the Hawaii Medical Association to the consideration of the aging process.



DR. GILBERT

In selecting this panel of experts, there was some concern that there might be controversial issues. And well there should be. I therefore trust there will be enough disagreement to provoke serious thought on the matter and enough agreement to let us know in what general direction we must move to work out the major problems of the aged.

These, then, are the facts, the interpretation of the facts and specific recommendations. My appreciation to the panel for meeting with us here this morning, and I can assure them that we, as physicians and citizens, will continue to battle all of those forces which would rob our senior citizens of the dignity and peace and position within our society that they have earned.

Thank you.

Health and Aging

LEO BERNSTEIN, M.D.*

The medical and sociological problems of the ged overlap. Economic insufficiency, social isolaion, and chronic disease are problems confronting he aged. It is important to emphasize that ecoomic well-being and social well-being are conidered to be inseparable from physical well-being. All that meets the eye in aging is not illness.

In meeting the needs of the aged, we are conerned with maintaining vitality and, equally imortant, happiness and a feeling of worthwhileness n living. Senator Pat MacNamara, Chairman of he Subcommittee on the Problems of the Aged nd Aging, reported to Congress that for the enoyment of life, the aged must have good health nd, at the very least, the assurance that the basic nedical costs can be financed.

A basic difficulty stems from the fact that family and individual responsibility have decreased while that of industry, labor, and government has increased as a result of the development of our industrial economy and urban society. Furthermore, as a result of the large number of the aged due to the increased average life expectancy, great social and medical problems have developed—the social problem of what to do and how to finance the care of large numbers of the aged and the medical problem of providing care for the large numbers of the chronically ill.

To meet this need, our social policy produced a change in the method of providing care and security for the aged, with industry, labor, and government assuming major roles. The problem for medical practice is that the organization of medical services depends upon social policies reflecting not only scientific advances but also patterns of family life and community organization. A social policy with restrictions on hiring and

Panel discussion at 104th Annual Meeting of the Hawaii Medical Association, Honolulu, May 12, 1960.
*Deputy Director of Health, Department of Health.

compulsory retiring of aged individuals results in economic insufficiency for maintaining a decent standard of living, which includes payment for medical services. A social policy resulting in social isolation of the aged—in not being wanted at work, not needed at home and with no dignified position in the community, in other words, not being wanted where they are or welcome anywhere else—results in socially induced illness. This increases the cost of medical and hospital care. This is what the Joint Council to Improve the Health Care of the Aged meant by their statement to the effect that older persons frequently need friends and companionship as much as pills.

The individual does not thrive in an atmosphere of rejection. He was made to be useful. The community has an obligation to prevent social illness by providing for the aged those psychological needs which are required by all people—the need for freedom and independence, which should be considered in providing housing for the aged; the need for companionship, to love and be loved and not socially isolated, which should be considered in patterns of institutionalization; the need to perform useful work, which should be considered in restrictive policies for hiring and retiring people; the need for emotional security as well as financial security, in considering income support for these individuals; and the need for community attitudes toward the aged conducive toward a dignified plac in the community. This is a responsibility of th community.

The physician has an important function in th area. Obviously, he should never abandon an of these patients. The physician's role in the agin has been stated as providing comfort always, prc viding relief frequently, and providing treatmer occasionally. The physician must be health rathe than disease oriented. He must not confine hi activities to measuring the degree of disability bu of the capabilities of these people. He should prc mote the philosophy of rehabilitation by encourag ing these oldsters to live up to the hilt of thei capabilities, rather than within the limits of thei disabilities. The physician should help the patien to maintain the psychological outlook of "wantin to die with his boots on."

We need to know more; we can do better tha we are doing with the knowledge we have; an we need to tell our story much better. For example the American Cancer Society has indicated tha we are now increasing the life expectancy for abou one-third of cancer patients; we have the knowl edge to help another third if they would reduc the time in obtaining treatment; but we need nev knowledge to meet the needs of the other third o cancer patients. Availability of services does no alter these facts.

Role of Government

MORRIS G. FOX*

As a group of physicians you are all concerned with the role of government in dealing with the problems of the aged. First as citizens, second as taxpayers, and third, and probably most important of all, as practitioners.

Economic Support

First, a look at the highlights of what is happening in Hawaii so far as the aged population and their economic support is concerned: It is estimated that there are approximately 29,000 persons in Hawaii at the present time who are 65 years of age and older.

1. Of these 85% are receiving some form of public or private retirement benefits.
2. 5% are receiving economic assistance from the Department of Social Services.
3. The remaining 10% are either living on their personal resources, support of relatives or inadequate income from other sources.
4. 90% of those 65 years of age and over have an estimated annual income of less than $3,600.

What is the government doing in Hawaii?

1. 75% of those 65 years of age and over are receiving "Social Security" benefits as retire workers or dependents of retired workers.
2. Others are receiving government benefits such a veterans' benefits, civil service retirement benefits railroad retirement benefits, and Armed Forces re tirement benefits.
3. 5% are receiving "Old Age Assistance" finance jointly by the Federal and State governments. I is significant that the number of aged receivin Old Age Assistance is steadily decreasing despit the increase in the number 65 and over.
4. In addition to the above there are fringe benefit in the form of tax breaks, special provisions fo financing housing, and, of course, medical care fo those unable to meet such costs.

Social Services

Let us now turn from the role of government i the field of economic support to the vitally im portant role that the government is playing i providing *social services* designed to preserve self respect and promote well-being and thus reduc the ultimate burden of the growing ratio of age to total population. These services contribute to more useful and productive life for retired person and consequently reduce the period of dependenc

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nd illness. There isn't time to do more than high-ght these. They include such services as:

1. Arranging suitable housing so that retired persons are not "shelved" in institutions but are allowed to live normal lives in their own communities in contact with their families and friends.
2. Arranging for those unable to care for themselves (and who have no families able to look after them) to receive substitute family care in "personal care" homes.
3. Counseling retired persons in the use of available community services and how best to deal with their personal and family adjustment problems.
4. Helping them secure employment.
5. Arranging for retired persons to remain active and make a positive contribution to society through volunteering their services in community agencies.
6. Encouraging attendance in adult education and university courses thus giving many retired persons a chance to catch up on things they never had time for during their earlier years.
7. Arranging recreational programs suited to the wishes of the aged.
8. Encouraging participation in physical fitness activities.
9. Promoting participation in mental health activities.
10. Assisting elderly persons in securing necessary legal aid.
11. Helping retired individuals with budgeting and planning their personal finances.

The increasing emphasis in government is to *help the aged to help themselves* and to work with voluntary agencies in setting up necessary programs and facilities to reduce the hazards, disappointments and sorrows of old age.

Insurance Against the Costs of Medical Care

Unfortunately there is not time in which to review all the activities of government in Hawaii or in the Nation. One of the recent developments which I am sure you have all been following intently is the role which the government may play in connection with health insurance for the aged of our country. With four such major proposals before Congress some action will probably be taken in the near future.

Cultural Aspects of Aging in Hawaii

ANDREW W. LIND,* Ph.D.

The relative youthfulness of Hawaii's popu-tion as compared with that of continental nited States is perhaps chiefly responsible for ie prevailing public indifference to the problems f aging but even the studies which have been ade of the older elements in the population iffer from a preoccupation with conceptions and iewpoints which are more appropriate to the con-nental scene. For while Hawaii is assuredly merican in its orientation and perspective, it ossesses in this instance certain peculiar advan-ges over the Mainland of the United States hich we can ill afford to disregard. Hawaii's low tio of aged (4 per cent 65 years of age and over 1 1950 as compared with 8 per cent in Conti-ental U.S.) is of course another decided advan-ge to Hawaii by affording more time in which plan intelligently for meeting the problem, roviding we also take account of the local or ultural peculiarities which differentiate us from ie mainland.

Most intelligent observers of the American ocial scene would admit that many of our tradi-onal procedures of dealing with the aging popu-tion are neither intelligent nor particularly hu-nane. To assume, as is so commonly the case in Western business and government, that an indi-idual who has been at the peak of his productive apacity suddenly loses that capacity completely hen he reaches his sixty-fifth birthday, and that, ke an over-worked draft animal, he is hence-forth fit only for the pasture, simply does not make good sense, and we are gradually discovering that it does not pay. This practice presumably developed out of the cold-blooded, calculating concern of Western industry to derive the maximum return from its labor and to replace it when the period of maximum productivity is past. Such competitive pressure still expresses itself in the common tendency throughout Hawaii among employers who hesitate to accept a new worker after he has reached the age of forty-five. Although Westerners would not willingly permit an aged person to starve for lack of food, our treatment of the aged, through our system of pensions, social security, or retirement allowances which permit little more than keeping together of body and soul, is frequently only slightly less inhumane.

Insofar as Hawaii is becoming progressively more Westernized and Americanized, it inevitably shares in this tradition, but by virtue of a vigorous Oriental and European peasant heritage there is also the basis for a more effective and intelligent handling of our problem of the aging. Well over 50 per cent of our population are only one or two generations removed from a culture whose cornerstone was filial piety, and our people of Oriental ancestry, including those of the third and fourth generations, are still highly responsive to the proposition that a person's prestige and significance increase with his age.

To those who adhere to this tradition, retirement from the responsibilities of earning a live-

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lihood is not a stepping down, as it commonly is in the Western world, but rather an advancing to a position of greater honor and veneration. The Confucian doctrine that children should "please, follow, and support their parents during their lifetime and mourn and ritually sustain them after death" underlies the greater support and respect which children of Oriental ancestry commonly manifest toward their parents even in the third and fourth generation of residence in Hawaii.

It has been suggested that the same feelings of tenderness and chivalry which Westerners have during the past several generations expressed toward the female sex were traditionally observed by Orientals toward their aged. This might take the form of permitting and encouraging the parents to withdraw from active economic and physical activity even though they are both quite capable of continuing their labors. Such a shifting of the burdens of household support from father to son and from mother to daughter-in-law does not imply that the usefulness of the parents has diminished because they no longer provide the economic support or material care of the household; rather, it is a gesture of love and appreciation for the infinite kindnesses rendered earlier by the parents. Retirement thus becomes the golden age, to be spent in leisure and comfort after the responsibilities of adult life have been adequately discharged.

Quite obviously, the secular and individualistic atmosphere of Western society is increasingly penetrating the whole of Hawaiian life, and is to that degree undermining the traditional attitude of deference and respect toward the aging which were introduced most markedly by our immigrant from the Orient. Yet even in the third and fourth generation immigrant families there is a significant survival of these traditional values in ways to enhance the enjoyment of the years of retirement and to reduce the burdens which are so commonly associated with old age in the Western world. With the passage of time the influence of the immigrant values may be expected to diminish, but it would be well to capitalize to the maximum upon the advantage which Hawaii now enjoys in this regard. Our schools, churches, and other community agencies, including the press, can perform a significant service to the people of Hawaii by giving moral support to the perpetuation of these cultural practices from the past.

It is worth noting in this connection that the older moral tradition of the West, insofar as it also is derived from an earlier peasant culture, gives at least lip-service to the conception that advancing years add to a man's stature and prestige. Certainly the Judeo-Christian heritage of Europe and the Americas accepts unquestioningly the supposedly divine commandment, "Honor thy father and thy mother that thy days may be long," and the associated notion that "With aged men is wisdom and in length of the days understanding." In this respect, East and West share a common moral imperative.

Perhaps one of Hawaii's significant contributions for East-West studies may be in the searching out of more effective ways of reducing the conflict between the dictates of conscience with respect to the treatment of the aging and the pressures of an impersonal and highly competitive world economy.

Role of Hospitals

KENT LONGNECKER*

Everyone concerned with the health care of the chronically ill and aged—and that includes hospital officials, federal and state agencies, and the general public—agrees that facilities for long-term care must be expanded and improved. Agreement ceases at that point, however. What such facilities should include, who should sponsor them, where they should be situated, and whether they should be large or small, high rise or one-story, are matters for debate in hospital meetings, government hearings and the press.

From a community or a state-wide standpoint, there is a serious lack of planning for the integration and coordination of services which will provide for continuity of care consistent with the changing needs of the patient. Too little attention is being paid to providing an adequate staff and achieving the proper affiliation among the various types of existing care facilities and services.

Good care is expensive for the individual and for the public, and it is inevitable that the public either directly or indirectly will be assuming more of the cost of providing facilities and services for long-term care as the population grows older, particularly for those whose resources are not adequate to meet their health care needs.

We are, and probably always will be, faced with a critical shortage of well-trained professional and technical personnel in the health field. Therefore, every possible consideration must be given to avoiding the development of small, inadequately staffed inferior services, which only duplicate and tend to accentuate existing personnel shortages. Such duplication and separation are too expensive from the standpoint of the health of the public as well as the economy of the nation.

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It is most desirable that older persons remain their own homes as long as possible.

The provision of intensive nursing care under od medical direction represents the most acute ed in the nursing home field today, and it there- re becomes apparent that we must plan a con- derable portion of our nursing home beds in its or wings of community hospitals. There are least 10 advantages in a combined hospital- ursing home operation, as follows:

1. Good medical direction is readily available as needed.
2. More efficient utilization of existing nursing personnel and an improved nursing service are possible.
3. X-ray, laboratory and other diagnostic services are available when needed.
4. The services of such specialized personnel as social service workers, dietitians and medical record librarians can be utilized by both the hospital and the nursing home.
5. Greater flexibility in the administration of the hospital can be achieved by freeing beds occupied by long-term patients who do not require acute hospital care.
6. A smoothly operating mechanism is provided for the transfer of patients from the hospital to the nursing home or the reverse as the needs of the patients change.
7. There can be a joint utilization of rehabilitation facilities and personnel by the hospital and the nursing home on both inpatient and outpatient basis.
8. Opportunities are provided for training all types of hospital personnel in the care and rehabilitation of the long-term patient.
9. Basic facilities and services such as kitchen, laundry and boiler plant, can be utilized jointly.
10. The combination of hospital and nursing home offers the advantages of joint purchasing and a single administration.

If our rapidly expanding needs for modern care facilities and quality services are to be met, much greater emphasis must be placed on careful long-range planning, cooperation and integration of all facilities and the active support of all concerned.

Medical Insurance for the Aged

RICHARD E. HAGER*

During recent years, one of the major problems nfronting the insurance industry has been that providing adequate medical protection for the ed. Increasing demands by employers and unions ve stimulated the voluntary health insurance dustry into providing a wide variety of benefits om which our senior citizens may choose.

The Health Insurance Association estimates at, by the end of 1960, 65% of our population er age 65, wanting and needing health insur- ce, will be covered by one of the many plans ailable. A few approaches to provide these ben- its are:

Group insurance policies providing continuation of benefits on retired employees.
Conversion privileges under group medical programs.
Plans which become paid up at age 65 by pre-funding during the active employment years.
Individual policies providing a level premium, non-cancellable provision issued during early years at an increased rate level.
Mass enrollment on retired employees.
Benefits paid from funds available under a post-retirement group life insurance schedule.

he doctor's role is most important to the con- nued growth of this protection on a voluntary asis. The American Medical Association has pro- osed a solid platform of establishing lower fees r those patients over age 65 with a low income vel. Seven major states have acted on this rec- mmendation and 34 other state medical societies e to consider the recommendation during 1960.

Pending Federal legislation to provide benefits through the Social Security system, commonly called the Forand Bill, has many pitfalls. As an example:

1. The Forand Bill does not cover the more than four million men now over 65 and women over 62 who are neither covered by nor eligible for Social Security. Among this group are most of the indigent aged who are least able to pay for health care. *Thus, the bill fails completely to accomplish the purpose its supporters most often claim for it.*
2. The tremendous costs of "free" health insurance have been demonstrated by the experience of other countries, notably Great Britain where costs are running more than four times the original estimates made only ten years ago. Insurance actuarial estimates are that the costs of the Forand program would be more than $2 billion in the first year alone, spiralling to between $5.9 billion and $7.6 billion a year by 1980. These same estimates indicate that the amount of additional Social Security tax proposed to support the Forand program even in its first year (one-quarter of one per cent on taxable earnings of employees and one-quarter of one per cent on employers) would prove inadequate.

While the insurance industry is generally opposed to the Forand Bill, our industry recognizes the need for and we support assistance programs to supplement the efforts of voluntary and community agencies to provide for that segment of the aged population who cannot protect themselves. The question is not *if* but the soundest way to providing this care.

We believe with the assistance of the Medical Society the insurance industry and agencies at the state and local levels will continue to meet the problem of providing adequate medical care for the aged.

* Manager, Group and Pension Departments, Aetna Life Insurance ompany.

Skin Problems in Aging

SAMUEL D. ALLISON, M.D., Honolul

"So many cares, so many maladies,
So many fears attending on old age.
Yea, death so often call'd on, as no wish
Can be more frequent with them, their limbs faint,
Their senses dull, their seeing, hearing, going,
All dead before them; yea, their very teeth,
Their instruments of eating, failing them:
Yet this is reckoned life!"[1]

—BEN JONSON

THUS BEN JONSON described aging in the 17th century.

The poets have described it. The politicians are becoming interested in it. And some of us are beginning to feel it. It happens to us all, and in each of us it happens in a different way. It may most seriously affect one's heart, another's kidneys or brain, but in all of us it affects also our skins.

We may have conditions which in themselves are not serious but which in the aging can be devastating. Many oldsters are bothered with pruritus. Others tend to have their lifelong seborrhea become quite annoying and serve as a focal point for mycotic or other infections. All conditions associated with stasis are aggravated. Toenails become thick and irritating and fingernails split. The thin skin is easily traumatized and often minor injuries are followed by large ecchymoses. Some diseases cause suffering nearly in direct relationship to age, as for example herpes zoster which in the aged is often of the ophthalmic type and is frequently followed by prolonged neuralgia.[2] This is graphically represented in Chart 1.

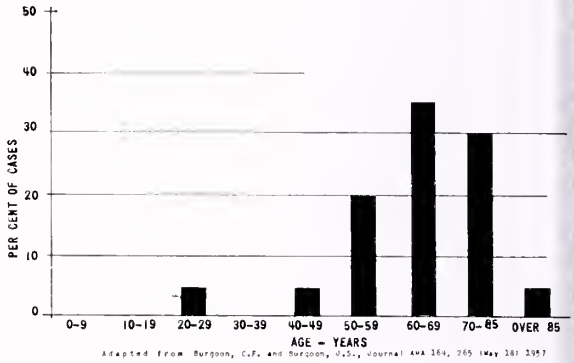


CHART 1.—*Distribution in various age groups of 20 cases of postherpetic neuralgia.*

Our problems may be such that we merely suffer through our appearance, or we may develop disease which without adequate care may cause disfigurement or death.

> When someone looks at anything, it's nothing or a many-thing
> The eyes of the beholder make it trivial or great . . .[3]

Baldness

It is not easy for many individuals to reconcile themselves to the loss of hair. Witness the immense advertising budgets for hair restorers, ha clinics, and even hair pieces. Hippocrates, cer turies ago, knew the only sure prevention for mal pattern baldness: "eunuchs do not take the gou or become bald."[4] The tenth century Celts wer sufficiently concerned with baldness to formulate local treatment: "let calcine a raven, his ashes bo in sheep's suet, and rub to the head, it cures." Today we have little to offer beyond the treatmen of a thousand years ago. In general we must relie seborrhea with the classical sulfur, tar, and sa icylic acid preparations or some of the newer su fide shampoos, sulfacetamide preparations, or the equivalents. In men, beyond this, often we can c little more than to assure the patient in the wor of Shakespeare that "There's no time for a man recover his hair that grows bald by nature."[6]

Hair loss in women seems to be an increasir problem. While this is not entirely a problem aging, it apparently is most marked in old

Read before the 104th annual meeting of the Hawaii Medical Association, Honolulu, May 13, 1960.

[1] Jonson, Ben: Volpone, Act I, Scene I.

[2] Burgoon, C. F., Burgoon, J. S., Baldridge, G.: The natural history of herpes zoster, J. A. M. A. 164:265 (May 18) 1957.

[3] Bean, W. B.: Omphalosophy and Worse Verse, Iowa City, Iowa, p. 5.

[4] Rapport, S., Wright H.: Great Adventures in Medicine, The D Press, New York, 1952, p. 49 (by permission of the publishers).

[5] Ibid, p. 92.

[6] Shakespeare, William: Comedy of Errors, Act II, Scene II.

omen.[7] No one knows why this condition is oc-
rring but some have speculated that it might
ssibly be related to the newer detergents. One
thority has suggested that ". . . as the women
sume more masculine activities the adrenal cor-
x is making sufficient adjustment to masculinize
me in a number of ways, including their scalp
ir."[8] In women with hair loss it is essential that
ssible systemic causes be evaluated and that local
ritating factors such as damage by brushes,
eaches, dyes, and traction be prevented. There
ems little doubt that the judicious use of estro-
nic substances both systemically and topically
ten is invaluable in adding life and longevity to
ir. As in the case of men, sometimes there is
ly one ultimate recourse; that is, the ". . . sure
re for baldness for men and women" offered by
local Honolulu hair clinic—a hair piece.

Unwanted Innocent Lesions

As hair falls from the head it burgeons in other
eas. And along with this changing hair pattern
her dermal and epidermal structures change.
Moles get larger. Skin tags become abundant. Se-
orrheic keratoses become darker and increase in
mber; sebaceous activity increases in men and
ecreases in women; "cherries" and "venous
kes" and "caviar lesions" become prominent;
e skin loses its pinkness and smooth texture and
s elasticity and it becomes dry. These changes are
ot significant to physical health. They are mostly
f cosmetic concern, but they add to the difficulty
f management of skin disease, and they add to
e complexity of diagnosing more serious skin
sions.

It is my belief that these conditions should be
rrected. For example, I have had a number of
atients with seborrheic keratoses develop basal
ell epitheliomas among the innocent lesions. Re-
ently I had a patient with changes in a life-long
errucous nevus of the scalp. Within this nevus
ad developed a basal cell epithelioma, a basal-
quamous epithelioma, and a large epidermal cyst.
ery likely the removal years ago of this verrucous
evus for "cosmetic purposes" would have ob-
iated the present epitheliomas. What should be
one about these "innocent lesions"?

Excess Hair: Most men shave off hairs in un-
vanted areas. Shaving is not desirable in women.
With the decline in estrogenic substance, coarse
nd dark hairs may grow on the chin. While men
re used to a smooth face, women depend on the
ine hair for the soft patina desirable in makeup.
believe electrolysis to be the solution to the sparse, coarse hair problem of aging women. It is safe, inexpensive, and gives satisfactory results.

Skin Tags: The fine papillomata (acrochordon) around the neck, in the axillae, and on the inner thighs increase as we grow older. They are not detrimental to health but they can be unsightly and often they bleed profusely if inadvertently pulled off. The minute ones are readily destroyed by fulguration. A simple way to remove the larger ones is with a hot cautery.



Bauer

DR. ALLISON

Senile Sebaceous Adenomata: These lesions occur chiefly on the forehead, infra-orbital regions and temples. They are yellowish, slightly elevated papules with a slight central depression. Under magnification they seem like rosettes made up of minute milia. They are primarily of importance as they simulate small basal cell epitheliomas. Usually they are too small to require treatment even for cosmetic reasons.

Seborrheic Keratoses: Seborrheic keratoses are among the simplest of skin lesions to treat. They are epidermal structures and need not be excised. My own choice of treatment[9] is to remove them with a curette. Superficial fulguration, cryotherapy, dermal abrasions, and other methods are all useful in the hands of those familiar with the techniques.

Lentigo Senilis: These are pigmented macules which occur on the backs of hands, the face, and occasionally elsewhere. They increase both in size and number with aging. "The specific etiology is unknown . . . Despite the lay term, 'liver spots,' the lesions of lentigo senilis bear no relationship to the general health of the patient."[10] Simple destructive methods such as electrodesiccation and curettage, or application of trichloracetic acid, may improve the appearance of the lesions. When dealing with these spots one should always keep in mind the possibility of melanotic freckles, the early slow-growing melanomas of aging which become malignant.

Nevi: Moles may be taken or left alone. I know of no authenticated instance of the removal of a nevus—in part or in its entirety—causing malignancy. Moles get larger (or sometimes regress) with age. If they are unsightly they may be excised

[7] Sulzberger, M. B., Witten, V. H., Kopf, A. W.: Diffuse alopecia
n women, Arch. Dermat. 81:556 (April) 1960.
[8] Behrman, H. T.: Personal communication to the author, April,
960.

[9] Allison, S. D.: Warts: vulgar and seborrheic, a simple method of removal, Am. Pract. & Digest of Treat. 3:544 (July) 1952.
[10] Cawley, E. P., Curtis, A. C.: Lentigo senilis, Arch. Dermat. & Syph. 62:635 (Nov.) 1950.

completely or to the level of the surrounding skin. This affords an opportunity for tissue examination and provides both the patient and the physician peace of mind.

Vascular Lesions: The vascular lesions of skin are numerous. They are of both medical and poetic interest. Chart 2 illustrates the areas where these lesions commonly are seen.

Dr. William Bean[11] has devoted an entire book to them with one chapter dealing solely with vascular lesions of aging. He has described the pathogenesis of spider nevi (nevus araneus) in this inimitable fashion:

> An older Miss Muffet
> Decided to rough it
> And lived upon whiskey and gin.
> Red hands and a spider
> Developed outside her—
> Such are the wages of sin.[12]

While spiders often occur in normal young people and are frequent accompaniments of pregnancy and liver disease, they may increase with age. There are numerous other vascular lesions that seem closely related to the aging process itself.

Cherry Angiomas: This is a much more pleasant term than "senile angiomas." Few old people do

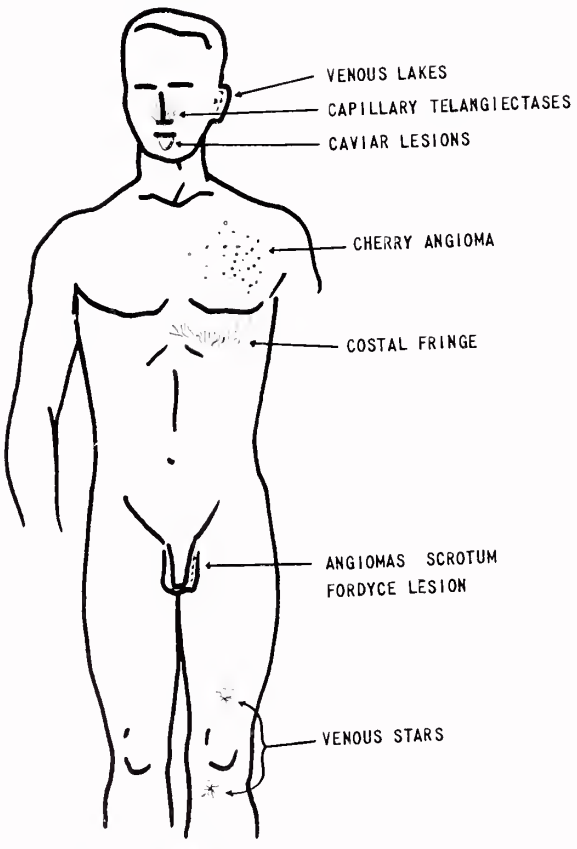


CHART 2.—*Usual sites of usual vascular lesions in the aging skin.*

[11] Bean, W. B.: Vascular Spiders, Charles C. Thomas, Springfield, Illinois, 1958, p. 227.
[12] Ibid, p. 86.

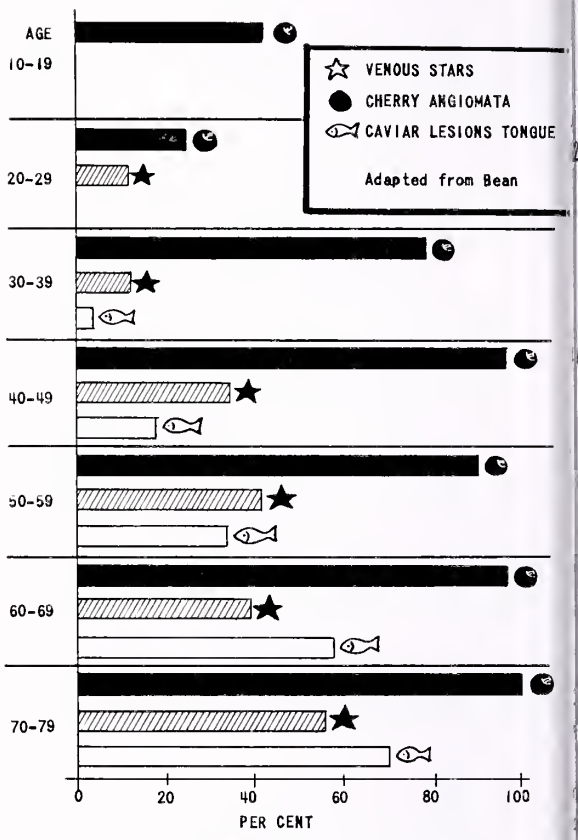


CHART 3.—*Age distribution of three commonest vascular lesions in the aging skin and mucous membranes.*

not have these small red vascular papules over their chest or back. While they are not related to health, disease, or neoplasm, they are inelegant and are readily destroyed by fulguration. *Venous stars* are little varicose veins. They do not pulsate as do spiders, and are usually in areas where there is some increase in venous pressure, such as the legs and thighs. *Venous lakes* are bluish red blister-like lesions most commonly seen on the ears. *Caviar lesions* are clusters of dilated and varicose veins hidden under the surface of the tongue. Many patients past middle age have a *costal fringe* of dilated veins running around the lower portion of the chest. On the face and nose are seen *capillary telangiectases* in health but perhaps more frequently in liver disease. On the scrotum may be found small angiomas or *angiokeratomas of Fordyce*. These are of no concern other than cosmetic unless they are irritated and bleed.

Chart 3 shows the increase in a number of these lesions with age.

Skin Cancer

Up to now we have discussed conditions that merely annoy the older patient. Some skin problems, such as cancer, are serious from the standpoint of disfigurement or health.

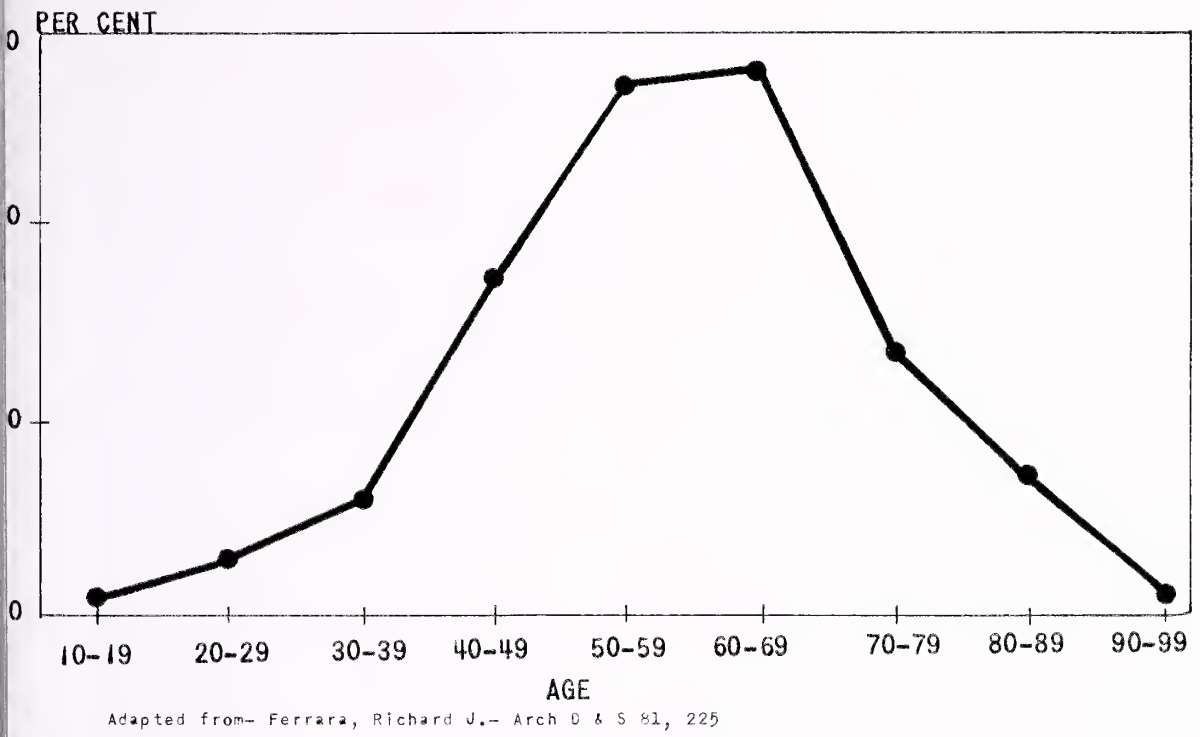


CHART 4.—*Age analysis of patients with epitheliomas.*

Some years ago there is said to have lived a ockroach by the name of Archy. Archy, the re-carnation of a blank verse poet, often came out night and jumped up and down on the keys of on Marquis' typewriter. The late Mr. Marquis ublished some of Archy's philosophy including he poem entitled "the lesson of the moth."[13]

i was talking to a moth
the other evening
he was trying to break into
an electric light bulb
and fry himself on the wires

why do you fellows
pull this stunt i asked him . . .
if that had been an uncovered
candle instead of an electric
light bulb you would
now be a small unsightly cinder
have you no sense

plenty of it he answered
but at times we get tired
of using it
we get bored with the routine
and crave beauty
and excitement

fire is beautiful
and we know that if we get
too close it will kill us
but what does that matter
it is better to be happy
for a moment
and be burned up with beauty
than to live a long time
and be bored all the while . . .
that is what life is for
it is better to be a part of beauty
for one instant and then cease to
exist than to exist forever
and never be a part of beauty . . .

we are like human beings
used to be before they became
too civilized to enjoy themselves

Really, people are not unlike the moth. During recent years we have all witnessed the craze for sunbathing and we are beginning to reap the harvest of premature skin aging and the resulting actinic keratoses and epitheliomas. Alexis Carrel is said to have kept chick embryo heart cells alive and healthy for thirty-four years. It may be that much damage to skin is not inherently related to aging. Physicians have been aware that factors extrinsic to the skin provoke cancer ever since 1775 when Percival Pott described "soot warts . . . a superficial, painful, ragged, ill-looking sore, with hard and rising edges."[14] For years it has been known that it is the worker exposed to large quantities of sun who is inclined toward skin cancer. Numerous studies have indicated that most epitheliomas occur on the exposed portions of the body. A recent study in the Midwest has shown the ages and locations at which these cancers occur most frequently.[15]

This same study of 226 lesions revealed that 192 of them were on the head, 20 on the extremities, and only 14 were on the trunk.

[13] Marquis, Don: Archy and Mehitabel, Doubleday and Company, ic., New York, 1939, pp. 98-100 (by permission of the publishers).

[14] Combes, F. C.: Coal Tar and Cutaneous Carcinogenesis in Industry, Charles C. Thomas, Springfield, Illinois, 1954, p. 35.

[15] Ferrara, R. J.: The private dermatologist and skin cancer, Arch. Dermat. 81:225 (Feb.) 1960.

Studies carried on in Hawaii[16] have rather conclusively demonstrated that skin cancer is a problem not of all races, but is nearly exclusively the concern of the white man or woman.

TABLE 1.—*Skin Cancer Incidence Rates per 100,000 Population by Race, Honolulu County, 1955 and 1956*

RACE	RATE
Caucasians	138.0
Non-Caucasians	3.1
Korean	17.8
Chinese	4.8
Japanese	3.5
Hawaiian and Part-Hawaiian	1.6
Filipino	1.4

These studies, correlated with studies done by the United States Public Health Service, also indicated a higher incidence of skin cancer the closer to the equator one lived.

TABLE 2.—*Skin Cancer Annual Incidence Rates per 100,000 White Population, Honolulu County, 1955 and 1956; Selected Mainland Areas, 1947, 1948*

AREA	YEAR	RATE
Honolulu	1955 and 1956	138
Dallas	1948	109
San Francisco	1947	90
Philadelphia	1948	39

It would seem, then, that there is more to the problem of skin cancer than aging itself. If sun is a major factor we must do what we reasonably can to prevent damage. Hats are helpful. Numerous sun creams and lotions screen out the ultraviolet rays. The judicious use of the antimalarial drugs is helpful to some people. The status of the psoralens is being determined and until more information is available I do not believe these drugs should be used indiscriminately to encourage tanning. I believe that many very early precancerous changes in the skin can be reversed by lubrication of the skin and there is evidence that topical use of hormones improves the health of aging skin.[17]

Recently a rather dramatic approach has been made toward the prevention—or massive removal of early precancerous changes. I like to term this procedure "epidermectomy."[18] By removing the epidermis by abrasion, incipient lesions are destroyed and the development of new lesions is markedly reduced. This procedure became fairly simple after the introduction of the Kurtin technique for skin planing. I recently checked a patient whom I had abraded for this purpose in 1955. She had new epitheliomas on her neck and shoulders, but in the abraded areas of the face n new lesions were occurring.

Soon to appear in the literature[19] will be mate rial presented at the 1959 meeting of the Amer ican Academy of Dermatology which depict beautifully the pre- and post-operative results o dermal abrasion of the aging skin. Pre- and post operative histologic findings show dramaticall the youthfulness of the abraded portion of the der mis as contrasted with the deeper dermis.

But after all of these things are done—or fron failure to do any or all of them—we see patient with epitheliomas that must be treated. The bes treatment is one which cures, is elegant, and whicl provides the minimum of discomfort, expense and inconvenience to the patient.

Curettage and electrocoagulation is simple an inexpensive, provides biopsy material, and in som areas offers a satisfactory cosmetic result. It is ex cellent for precancerous lesions, small basal cel epitheliomas, and grade I squamous cell epitheli omas.

Scalpel surgery provides biopsy material. I must be sufficiently extensive to get at the pseudo pods — the tinkertoy or iceberg portions of th lesion. It is an excellent method for small cancer on the forehead where wrinkles permit good cos metic results, and it is the treatment of choice fo well-differentiated squamous cell epitheliomas.

Radiation (after biopsy) provides a high per centage of cures, conveniently may cover a wid enough area to take care of the pseudopods, an provides an excellent cosmetic result in certai locations.

My favorite approach for a number of lesion is the combined use of the curette and radiation A semi-sharp curette is used to remove the sof epitheliomatous tissue and to provide a biopsy specimen. By combining minimal curettage wit divided-dose radiation, excellent cosmetic result are often obtained. No physician should limit him self to a single treatment modality.

Shakespeare will end this paper:

> Slanders, sir: for the satirical rogue says here that old men have grey beards, that their faces are wrinkled, their eyes purging thick amber and plum-tree gum, and that they have a plentiful lack of wit . . .[20]

Summario in Interlingua

Es presentate un revista detaliate del lesione cutanee que es associate con le processos del in vetulation. Es discutite le tractamento de ille le siones. Pertinente citatos es tirate ab le litteratur professional e laic.

[16] Allison, S. D., Wong, K. L.: Skin cancer, Arch. Dermat. 76:737 (Dec.) 1957.
[17] Goldzieher, J. W., Roberts, I. S., Rawls, W. B., and Goldzieher, M. A.: Local action of steroids on senile human skin, Arch. Dermat. & Syph. 66:304 (Sept.) 1952.
[18] Allison, S. D.: The new, newer, and newest, Arch. Dermat. 79:596 (May) 1959.

[19] Chernosky, M. E., Houston, Texas. Smith J. G., Jr., formerly Assistant Professor of Dermatology, University of Miami School o Medicine, Jackson Memorial Hospital, Miami, Florida.
[20] Shakespeare, William: Hamlet, Act II, Scene II.
305 Royal Hawaiian Ave.

A major Honolulu asset in the health field is reviewed by a distinguished friend of long standing

Planning for Public Health Progress in Honolulu*

A Year of Appraisal and Dedication for the Oahu Health Council

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THE HEALTH COUNCIL aims to provide an opportunity for persons concerned with ealth to share ideas and to act on community health needs. A timely, well-balanced community health program is the goal. We must help with interpretation and communication of facts. We must find ways to implement conclusions through cooperative action.



DR. HISCOCK

This is an age of rapid movement and of person-to-person diplomacy. Everyone is important, as illustrated by the Nevada farmer who cut the East-West cable, suddenly stopping verbal communication of millions, and by the "unrepresentative" urist. For new Frontiers of Living, the world is rged to put thinking back in style. Dr. Alan Waterman, Director of the National Science oundation, has said: "We are not likely to harvest healthy crop of excellence in a land where athetes and night club entertainers are held in igher esteem than scholars, professional men nd women, and the teachers of our children. We eed to create in America the same regard for chievement of the mind as we now have for chievements of a more material sort." A columnist wrote recently that we have had our fun ooking down our noses at long hairs who think. We've laughed as Robert Cummings said to oretta Young in a movie they made together, "You're bewitching, darling, your brains don't show a bit." It is time to let brains show, says the columnist, who adds that this may be our escape from a fate as bad as fission or fusion—the fate of emptiness, and a former Director General of World Health Organization discusses SURVIVAL as the new concept of health. Are we really to be a part of the last surviving generation on this Earth? At least, unless something more constructive is done soon?

The Situation

The Oahu Health Council accomplishments are impressive. The new challenges are tempting. Yet the unfinished business is staggering for the small staff and the otherwise busy board and committee members. Everyone is busy. Everyone is pressed for time and attention. Meanwhile, promising untilled fields are before our eyes. The basic structure looks well and appears to be solid until one examines the foundation stones of financial, professional, and nonprofessional participating support. Except for the Public Health Committee of the Chamber of Commerce, modest essential foundation grants, and a growing number of industrial and individual memberships, the financial allocations of those agencies for which the Council is a "strong right arm" are only tokens. Several additional organizations should be "aboard." How much Health counts for Peace and Prosperity and Progress! Questions such as definiteness of focus on health, adequacy of follow through before taking on new tasks, balance of program while keeping in tune with the times, worry those at the helm.

Yet we may quickly and fearfully exclaim "What would be the situation if there were no Health Council!" The Council is doing a great job; it needs more help; it deserves more support by all concerned, in partnership—professional and nonprofessional—paid and volunteer. The

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work is satisfying in spite of Frederick Lewis Allen's Law, enunciated in *This Week:* "Everything is more complicated than it looks to most people." Whereupon his wife, Agnes Allen, said: "Almost anything is easier to get into than to get out of."

The situation differs from many in the United States where the official health department and guiding staff members may be less effective than here. Here, too, the voluntary health agencies are equipped with few staff members who are prepared and experienced in community organization and health education of the public except some who are busy executives raising money. A review of the outlines of activities in other local health councils in 1959 fails to yield many suggestions for Honolulu, partly because of differences in circumstances even though principles and policies of operation are similar.

Among the more common interests were jointly sponsored committees, here and there, to consider means of strengthening of health services and facilities and to learn of unmet needs, such as:

1. Nursing homes and so-called convalescent hospitals.
2. Assistance available from Volunteer Office with others in recruiting Friendly Visitors to patients in nursing homes.
3. Home accidents and safety through a co-sponsored study.
4. Gaps and strengths in the community dental health program for adults and children.
5. Concerns in several places for a comprehensive Home Care Program, with definition of need and provision of service, including how to finance and staff properly.
6. How to plot in Rochester, for example, a better community plan for care of chronic illness and rehabilitation among all ages.

Historically, the health council movement is young. The National Health Council was born on New Year's Day, 1921, under the presidency of the late Dr. Livingston Farrand, later President of Cornell University and head of the American Red Cross, ably assisted by the late Dr. George Vincent, President of the Rockefeller Foundation, and Dr. Lee K. Frankel, Vice President of the Metropolitan Life Insurance Company. The idea for joint planning and coordination of efforts came much earlier in the United States, however, as illustrated by the proposal of the great lawyer and statesman of Boston, Lemuel Shattuck, in the 1850 Sanitary Commission Report for Massachusetts, that "a Sanitary Association be formed in every city and town in the State, for the purpose of collecting and diffusing information relating to public and personal health." Countless numbers across America have wished to help with the plan.

Let us consider briefly a few highlights of the setting. Over three quarters of Hawaii's people, numbering almost 700,000 with those in the armed forces, but exclusive of the large number of tourists (6,000 daily), live in Honolulu City and County. The number and kinds of voluntary agencies are similar to those in the urban portions of the other states, especially the more prosperous states. There is a greater variety of cultural, racial, and religious groups than found elsewhere. Nowhere is there more beautiful scenery and chances for relaxation, with harmony, and educational and medical resources. Housing and real estate booms, low unemployment, younger than average population, excellent health record, and rising standards of living are other prominent features.

What place can say more readily that there has been no smallpox for 45 years, practically no typhoid fever for 10 years, only one diphtheria death in 12 years, no rabies, no malaria, no yellow fever, one of the lowest tuberculosis mortality rates (although cases remain up), and low infant mortality? Practically all births occur in hospitals. Meanwhile, we are concerned about high incidence of arthritis, asthma, cancer and heart diseases, high home accident incapacity, and high dental caries. Alcoholism is apparently not decreasing much among either men or women, and mental illness and mental retardation exact a toll comparable with mainland places.

Plantation medical service is well rendered as an industrial program. Hawaii Medical Service Association and the Kaiser Foundation Health Plan offer group and individual health services, while several life and general insurance companies offer health insurance plans. Still the proportion of the people covered in sum total is unusually low.*

Most of the important voluntary health agencies are housed close together, on the same grounds with the Oahu Health Council, at the Lunalilo Health Center in the building owned by the Oahu Tuberculosis and Health Association. Only a few blocks away, in the Liliuokalani State Building, are located the Department of Public Instruction, the Department of Social Services, and the Maternal and Child Health, Crippled Children, and Nursing sections of the Department of Health, a few steps from The Queen's Hospital, the Mabel Smyth Memorial Building, and the new State Department of Health building.

The situation is changing as elsewhere in this complex world, while recent progress in medicine and public health is dramatic. Will it be strange if current studies in space medicine prove to be a great boon to the health and safety of all of us who are earth-bound? There has been a rising

* Health Insurance statistics places Hawaii with 45.9% coverage, up 14.3% over 1958, among the ten lowest states. New York with a coverage of 90.7% leads all states. Lowest is Alaska with 30.0%. [Ed.]

nterest in many phases of physiology, nutrition, nd general physical and emotional fitness. Adapability and responsiveness of the human body inluence success in space flight and receive attention n submarine life also. The attention given to the election and training of the astronauts has added o the appreciation of health. Studies in space nedicine also have thrown light on the problem f accidents. According to two noted research vorkers, "the physiologic studies about the effects f extreme of forces, carried out on rocket-powred sleds, have not only provided the knowledge f how to cope with the dynamic conditions durng launching and atmospheric re-entry, they are lso of greatest value for the analysis of mechanial injuries and protection in all kinds of traffic ccidents on the earth's surface."

Although the public generously donated milions of dollars to support research that led to olio vaccine, the public's response to it was very lisappointing to health administrators, epidemiologists, and other health officials. Public apathy oward taking the full series, the flare-up of parlytic poliomyelitis in the summer of 1959, in the Jnited States and Canada, and other factors raised he question of "Why?" The United States Public Health Service conducted extensive public-attitude urveys, and found that a major percentage of hose who failed to be vaccinated were in the ower socio-economic groups. Apparently, the meia of mass communication that helped to peruade 50 million people to take the vaccine failed o "register" with those in the lower socio-economic groups. Many of them believe that polio s no longer a threat, that the disease affects only hildren, and that it is relatively mild in adults.

These public-attitude studies brought out an mportant point. In some communities, public pathy to "polio shots" was overcome by personal ontact and by direct appeals from teachers, lergymen, and other community leaders. It would seem that mass communication must be supplemented by the active cooperation of local community leaders to stimulate the fullest participation n campaigns for the control of poliomyelitis. This ame lesson was learned years ago in campaigns for diphtheria prevention and for tuberculin testng, but was apparently forgotten or overlooked hree decades later.

The advancing front of virology; progress in surgery, including cardiovascular surgery; newer herapy for emotional disorders; and the drive for clean air, all promise much for the near future and have already opened new pathways to better living. Additional research is needed for guiding lights on radiation, on noise, on vision and hearing, and on medical genetics, besides the urgency of developing more reliable indicators or indices for the measurement of health and of public health practices.

Community Health Planning

More and more emphasis is being given to community health planning throughout the United States. What is our community? Its population? Its geographic limits? Its social, economic, and educational status? Its health facilities and personnel? The rates of births, illness, and death among its residents? Its community objectives and plans for action regarding the health of the people and of their families and their neighbors? Recognizing the marked effect on health services of voluntary health organizations, the following are among questions raised in our health inventory of Hawaii:

I. Issues include eight which are appropriate to mention here:
   1. Salaries to be watched, with appropriate financing in line with change and competition in other leading states.
   2. Civil Service barriers.
   3. Legislation changes needed, as emphasized by Dr. Richard K. C. Lee, as, for example:
      a. for improving operations following reorganization relating to mental retardation admissions and discharges.
      b. for upholding standards of the nursing profession.
   4. Medical and Hospital Care issues relating to the medically indigent and to other factors. The Health Information Foundation's recent careful analysis gives little support to the criticism that great numbers of patients are unnecessarily admitted to general hospitals or could be treated less expensively elsewhere.
   5. Effects on hospitals and their patients in Hawaii of new tests of doctors trained outside of the United States.
   6. Health education in communities and in schools.
   7. Job sharing of nurses and social workers, and adequacy of their staffs, including hospital social work staffs.
   8. Improved means of securing better bridges for rapid interchange of ideas and services in health, education, and welfare.

II. These lead to questions which require action, such as:
   1. In relation to the standards for the use of voluntary and professional association resources in our community health programs, are the contributions being made significant in their impact? A volunteer, like a Service Club man or woman, is esteemed for conduct as a citizen and devotion to dedicated service as well as for intellect and brilliance of oratory.
   2. What measures might be taken to develop further common community facilities and service?
   3. Recognizing that health planning cannot profitably exist in a vacuum, is there effective liaison and concurrent planning for needed social casework, hospital care, and recreation? Do the Council of Social Agencies and the Health Council develop their research projects together, when there may be a common concern?

4. In relation to the desirability for coordinated community planning for health services, are channels and methods of communication well organized between agencies and organizations and the general public so that the community is well informed when needs develop and programs are initiated? Is there a flexible pattern of priorities, which is reviewed periodically?
5. In addition to essential financial support of the health planning organization by local foundations and the Chamber of Commerce, do member agencies recognize their primary responsibility to provide directly or indirectly, the funds necessary to provide the staff services and secretarial assistance for this important function?
6. What additional steps are necessary to secure more effective joint planning and cooperative action toward the provision of better community health programs?

Conclusions for Tomorrow's Action

The Oahu Health Council's aims and purposes are constructive and sound in the light of 1960 conditions. It is a successful conference ground for many elements of the health movement. Much has been achieved by the wise use of a small devoted qualified staff and a modest budget supported by devoted board and committee members and well equipped for such guidance and participation. There is so much to be done by so few! In order that the time of busy volunteers, and of business and other professional people, may be used efficiently, much staff work has to be performed imaginatively and skillfully, with results presented clearly and concisely.

Among questions which appear in dreams of those who participate now, the following are illustrative and should be answered soon:

1. Can or should there be involvement of new people and areas of interest in the work of the Council? If so, where and how?
2. Should there be greater follow-through of projects at the expense of adding new pressing subjects for attention—depth, scope, content of attention?
3. Is there appropriate selection of activities designed to help local and state groups in the pursuit of health objectives? What is the relation to active state-wide Commissions, which have a tendency to increase?
4. Would a newsletter or bulletin again be helpful and practical?
5. How can more interaction be obtained among various parts of the Council program?
6. Should there be anticipated increased recognition of the Council, leading to new opportunities to be of more service to member agencies and to the cause of health generally?
7. Should there be a state health council, as there are in some 30 other states, with development and affiliation of councils for similar purposes in each of the counties of Hawaii.
8. Would there be mutual advantages for all concerned, especially for those served, by closer affiliation of the Health Council and the Council of Social Agencies?
9. Have the time and demands become sufficiently urgent to require at least the addition to the staff of a qualified associate in community organization and planning?

Lessons from the National

Some of the experiences of the National Health Council during the past dozen years are worthy of reflection, as given in the new president's address a few weeks ago. We have learned that the National Health Council can function more effectively if it remains neutral with regard to the question of the method by which the member agencies acquire their funds for their support, other than, of course, meeting certain ethical and accounting standards. This applies also to local and state councils. This does not mean that the Council should not provide the means for frank and objective discussion of this important subject. Over the years, too, we have made it clear that membership in the Council does not mean endorsement of the program of another member agency. A legislative committee can be helpful for various purposes.

We are in agreement that the National Health Council should not avoid having as the subject for one of its National Health Forums, as emphasized by President James Perkins, one which may be considered controversial, if that particular subject seems to be of the greatest current importance to the health interests of the country as a whole. But we also have established the policy that the Council itself will not come forth at the conclusion of such a Forum with a definite policy statement taking a stand for or against some particular approach or program discussed, which might or might not be in accordance with the individual policies of the member agencies.

"Does this then mean that the Council is a spineless creature, incapable of exerting any significant influence on the future improvement of the health status of the citizens of the United States? Not at all!" said President Perkins. "With the council representing the experience, the good will, the hopes and needs of many different groups involved in health programs (to borrow some phraseology of the late Dr. Alan Gregg's), it can study and clarify confused issues and act as a clearing house for information and opinions. Its authority will be great, not through *ex cathedra* pronouncements of policy, but through the authority conferred by the thoroughness, wisdom, and impartiality of its studies and its forums, and through bringing to the attention of groups concerned, the changing needs of the health program from year to year. But it goes beyond the realm of merely providing a forum for the exchange of

deas. In certain fields, through the assistance of pecial committees, and participation by nonmem-er as well as member agencies, it can promote nore effectively certain programs of common in-erest than can the individual agencies themselves; xamples are the program to interest young people n a career in the health fields, and the promotion f the establishment of more adequate local com-nunity health services.

"The future of the Council, in my opinion," ontinued Dr. Perkins, "depends to a large extent, pon the attitude of the member agencies, espe-ially the national voluntary health agencies and he professional societies. The attitude which hould prevail, I think has been best expressed by Dr. Dent, as quoted in the 1953 Annual Report of he Council. He stated: 'America's leading health rganization created the National Health Council —not as another organization—but as an exten-ion of themselves and their powers to achieve heir desired ends. The Council is in essence an-ther employee or department added to the staff f each of its members, ready to carry out tasks of ommon concern to some or all of them.' Let me tress that philosophy further. The Council is not thing apart. We are the Council. There is no ational health agency which cannot achieve some f its objectives more effectively through its Na-ional Health Council. I would go further. There re some objectives which cannot be accomplished n any other way. An agency is myopic, indeed, in my opinion, if it thinks it can accomplish all of its wn objectives solely through its own endeavors."

No one has greater concern for people, families, nd neighbors than do the men and women of Ho-olulu. They are unwilling to be complacent and atisfied while the world rolls by. The theme of his annual meeting of the Health Council is For-ward to New Frontiers!

The 1960 community has so many organizations which are concerned with health, education, and welfare that cooperative planning and united action are necessary for the success of both the official and the voluntary agencies. When one considers this formidable total of agencies, each going its own way to do what seems best for its own "clientele," the possibilities are evident, on the one hand, for lost motion and cross purposes, or on the other, for a concerted program of health development with the elements interwoven.

It must be admitted that often there are obstacles in the way of a successful organization for council purposes. Usually the stumbling blocks are personalities, for an opinionated, self-centered, protective executive or board member in one agency may make difficult a working family with primary aims to help people in the community. Also, agencies interested in a single type of project often find it hard to appreciate the necessity of correlating their work in their "lot" with that of the large "field." But the value of a central council is so obvious today that competence, imagination, and patience help to surmount the difficulties.

In the development of research activities one observes a changed pattern, too. Only a short time ago most investigations were carried on by dedicated individuals working in modest facilities, usually in a university or medical school, and deriving their support from the institution. The equipment was likely to be simple, the studies, circumscribed. As research endeavors increased and multiplied, it became evident that many of the problems in the health and medical fields were dependent upon the knowledge of the underlying chemical, physical, and biological sciences, more recently embodying also the social sciences.

These developments opened previously untapped reservoirs of knowledge that have brought understanding of many of the mechanisms of life and of disease and incapacity. Promises for advances in the future are great. There are no longer sharp lines of division or watertight partitions because nature, including man, is in one piece. Replacing the dedicated solo investigator is the team effort because no man alone can master the major phases or intricacies of any set of problems. Partnership in concepts has led to study groups which have pooled their thinking and efforts without hampering the incentives, interests, and inventiveness of separate contributors.

These changes have occurred largely as voluntary efforts. The Health Council is also a voluntary process. Just as voluntary health organizations have had a marked effect on health services, so are health councils helping to increase the benefits of public health. The voluntary health movement during the past 60 years illustrates in a unique and telling manner how people will rally to help other people as well as themselves enjoy the benefits of the conquest of disease and the pleasures of living. May the rallying point of the Oahu Health Council be ever charged with penetrating rays of light and strength for reaching powerful objectives!

Summario in Interlingua

Le Consilio Sanitari de Oahu es un organisation sin objectivo lucrative de agentias sanitari e de laicos e medicos individual qui se interessa a provider un opportunitate pro personas concernite con le sanitate del communitate a excambiar ideas e a prender action relative al requirementos sanitari del communitate. Le autor presenta un revista del propositos, methodos, objectivos, e financias del Consilio.

Health care problems for persons over 65 present a challenge in Hawaii, as elsewhere

Looking Ahead to Health in Hawaii for Senior Citizens

SHOYEI YAMAUCHI, M.D., Honolulu

THE SENIOR CITIZEN, today, desires to continue to live a normal life, unrestricted, unsegregated, and independent. He wants no part of being placed in a special group of needy and problematic citizens. However, in this disturbed post-war world, he finds it increasingly difficult to grow old while maintaining economic independence and self respect.



Bauer

DR. YAMAUCHI

In Hawaii there are approximately twenty-nine thousand persons over sixty-five. Five per cent are now destitute, aided by old-age assistance. An undetermined number of near-needy elderly are unable to meet the cost of adequate medical care, especially when costly hospital care is added.

The Need for More and Better Facilities and Services

Present day facilities and services for long-term care are not only inadequate, uncoordinated, and poorly utilized but also very expensive. By developing a coordinated and well balanced program, better care can be given at lower cost. This requires the development of a central agency at county levels to plan, coordinate, and develop the needed facilities and services and to carry on guidance and educational programs directed at the preservation of health and prevention of diseases. A state-wide permanent commission to plan, arrange, develop, and coordinate the total program is a need of first priority.

Home-Care Program

To keep the elderly sick with long-term illness in a home environment, there is need for a sound home-care program. This program should be based on a team approach by physicians, nurses, social workers, and others as needed, well coordinated and integrated to meet the need of the individual patient.

First started at Montefiore Hospital in New York, such a program has been working successfully for almost ten years. It provides good, well rounded care for many with long-term conditions now occupying expensive general hospital beds and for those who are now unable to afford such services. The development of this program in Hawaii will help socially and financially and keep many patients at home. This will in turn free expensive hospital beds for those who need them and save many communities considerable cost.

Nursing Home Care

Where home care is inappropriate, nursing homes would be needed. Standards of many of the existing nursing homes need to be raised and their number increased to cover both mental and physical disabilities. Minimum standards for licensed nursing homes are now required in Hawaii, but not enforced due to the shortage of those that qualify. There are now federal programs for the provision of grants through Hill-Burton mechanisms for new nursing home additions to existing hospitals. The recent amendment to the Federal Housing Act providing for guaranteed mortgage loans to proprietory nursing homes would probably stimulate development along these lines. A rapid improvement in the quality of medical care provided in nursing homes could come if encouraged by physicians and hospitals.

Better nursing home facilities for the long-term care of the aged, especially those over 75, is urgently needed in every community. The average nursing home patient is eighty years old, and the average duration of stay two years, nationally. In Hawaii, insurance coverage for nursing home services should be made available.

Hospital Beds for Long-Term Care

Hospital beds for chronic diseases are either totally lacking or inadequate in number except for

the destitute or medically indigent. The total of fifty-one beds in this category affiliated with general hospitals are in county hospitals, except for St. Francis Hospital, which has fourteen beds for long-term care. There is an urgent need to develop units for long-term care in all hospitals. Here the forgotten man is the near-needy, who can well profit from such an addition, since long-term beds are not now available to many in this category.

Empty beds in Hawaii's tuberculosis sanatoria are now being considered for conversion for care of long-term mental and physical conditions. However, national experience has shown that units for long-term care are best developed as wings of mental or general hospitals.

Rehabilitation

Rehabilitation facilities and services are either totally lacking or inadequate in many areas throughout Hawaii. The Rehabilitation Center of Hawaii, which is privately owned and has twenty-one beds, is the only institution with a complete rehabilitation program. Better utilization of the Center's excellent facilities and services for serious rehabilitation cases, too complicated to be cared for in general hospitals, would increase its usefulness.

To instill meaning into the total program of the chronically ill, infirmed, or aged, a pilot study in this direction will soon be underway under the auspices of the state Department of Vocational Rehabilitation and the Department of Health, with the blessing and support of Hawaii Medical Association. The stimulus for this project was supplied by the Governor's State Institute on Rehabilitation, held in January, 1960.

Medical Insurance Plans

The cost of medical care could be spread out on a long-term basis. Voluntary health insurance for people 65 years and over is now available, and more and more retirees are covered in Hawaii. Premiums are kept low because the cost is spread out among the 187,000 members of the Hawaii Medical Service Association (HMSA), a nonprofit, lay-controlled, medical-society-supported, voluntary organization, affiliated with Blue Shield and doing the job of Blue Cross as well. Health insurance for this group is also available from at least four commercial insurance carriers in Hawaii.

Hawaii's organized labor retirees have adequate health insurance coverage through extension of the insurance after retirement. Extension of health insurance, however, is not available to unorganized labor retirees.

Health insurance coverage is now offered specifically to those over 65 by at least two commercial carriers in Hawaii. Unlike coverages mandated by union contracts, these may be purchased by individuals without previous coverage.

Health insurance coverage is not now available in Hawaii for nursing home care, homemaker services, and many facets of rehabilitation, all of which are needed for the care of long-term conditions. Total coverage for these is the future goal for the health insurance carriers. Perhaps development of better and additional facilities geared for care of long-term conditions will lower much of the cost of medical care and make it possible for insurance carriers to expand and broaden their coverage. State and federal governments could profitably support such programs.

The state of Indiana is reported to be caring for the health needs of its senior citizens without recourse to Federal aid. Hawaii probably could develop similar programs. There are only 5% on old age assistance programs, which is one-fourth to one-third the proportion in other states. The near-needy must be equally few. The proportion of senior citizens in Hawaii is approximately half of that in other states. Hawaii's population is relatively young. Hence, there is a period of grace to develop programs unhurriedly and with care.

In a free society the development of voluntary competitive programs will be the only insurance against a permanent, compulsory federal scheme and guarantee continued growth in the health care of the senior citizens in the ever-changing times ahead.

Why Medical Care Costs Three Times More in the Elderly

Hospital Stay Is Longer

When those over 65 years enter hospitals for medical care, their average stay is 22.1 days as compared to 11.3 days for 45-64 group and 7.4 days for those under 45. These figures for Hawaii resemble those for the nation. Moreover, two-thirds of chronic diseases occur in those over 65.

The Nature of Chronic Diseases

Long-term illnesses occurring in the aged are characterized, as a rule, by their silent or insidiuous onset and a tendency to multiplicity and complexity, frequently punctuated by acute episodes under the influence of daily stress; and finally, many may be arrested but never leave completely. When acute diseases become superimposed on long-term conditions, the latter must be individually evaluated and treated in relation to the acute conditions. This would often require services of consultants and frequently additional x-ray, laboratory, and other procedures as well as care for the complicating conditions. Hence, the cost of medical care frequently becomes multiplied. The

ultimate goal of chronic disease control is prevention through research, the immediate needs are better facilities and services geared to reduce the cost of care without sacrifice of quality—better care through improved programs.

Hawaii Ideal for Research on Aging

The East and the West have coexisted in Hawaii for over a century. Only since the second world war, however, has there been a gradual but sure disintegration of oriental family unity. Western individualism is on the ascendency. More and more aged orientals live apart from their children. What are the effects of this change on the aging process, physically, mentally and socially? A study to answer this question will help to clarify many problems of aging.

The Health Research Institute of the University of Hawaii might direct its attention to problems such as these when it becomes operational. Expansion of the University in health fields will assure this State adequate personnel, with specialized skills, to fill the many needs as health programs grow. Even today the State suffers from a shortage of skilled personnel in the health field. The forthcoming East-West Center will be certain to aid many facets of health problems, since health is an important problem in the East as it is in Hawaii.

Hospital-Care Costs

Nationally, hospital care cost is rising at a rate of 7 per cent a year. Rapid advancement of medicine and ancillary sciences is increasing the need for more expensive hospital services and facilities. Exactly how much monetary increase is occurring at individual community levels in the United States to meet these costs is not determinable. Costs of drugs and personnel are rising. Just where and when this increase would stop, no one is able presently to foresee.

What is the picture in Honolulu's general hospitals? In 1940 patients in ward beds were charged $3.00 to $4.00 a day; today the cheapest is $16.00 a day. Blood picture study at the laboratory cost $2.00 to $3.00 then; today it costs $5.00. X-ray of the chest was $5.00 now $10.00. Electrocardiograms were $5.00, now $10.00. There has been a proportionate rise all along the line.

Are these increases necessary? Is the public getting the maximum benefits out of their tax-free institutions? Are not patients in hospitals captives and without voice in the matter of hospital services they buy? These are some of the questions raised by doctors and others today. If medical care costs keep on spiralling, there will be more questions asked. It is the responsibility of a strong hospital council to look into these matters and, in cooperation with hospital boards, supervise the rising cost of hospital care. Hawaii's physicians are confident that this can be done.

How May Hospitals Be Improved

Progressive Patient Care

Hospitals in Hawaii are not now geared to fit their services to the needs of patients. When such services are geared to meet patient needs, better services are said to be available at lower cost. This is the basic concept of the recently tried "progressive patient care" or the Manchester Plan.

Hospital beds and services are here developed into special units to meet the individual requirements of patients—the intensive care unit for the seriously ill, the intermediate care unit comparable to our present hospital beds, the self-care unit where he can help himself, and the continuation care unit which could provide home-care programs.

For the total care of patients on short or long-term basis, this plan appears to be desirable. Now tried in part or whole by over 150 general hospitals, led by the Manchester Hospital since 1956, over 400 other hospitals in the nation were reported to be planning for it by early 1959.

Auditing Hospital Facilities, Services and Costs

Russell A. Nelson, M.D., the President of the American Hospital Association, has suggested "hospital examiners" comparable to the new existing "bank examiners" to better audit hospital facilities and services to maintain their quality and prevent excessive charges and abuses. Probably creation of such an agency will plug many holes which apparently exist today in many hospitals.

The Task Ahead

Hawaii needs to develop new, and expand and improve old, facilities and services to better meet the health needs of its senior citizens. There is a considerable undercurrent of fear of costly long-term diseases in their advancing years. It is sad but true that in this wealthiest of nations the cost aspect of health should be so magnified. Probably this situation has resulted largely due to the fact that sociological sciences have lagged behind, while medical and ancillary sciences have advanced with tremendous speed and the communities have not had time to keep abreast.

Health needs of senior citizens are well known to Hawaii's community leaders and there has been a good start. Rehabilitation is one of the fundamental aspects of chronic illness and aging cares. The Rehabilitation Center of Hawaii, developed by community leaders with Howard Rusk's help, has already shown what can be done by total re-

habilitation. The Rehabilitation Institute held in Honolulu in January, 1960, encouraged the many attendants from all over the state to take back with them the possibilities and the meaning of total rehabilitation. This Institute has special significance to the people of Hawaii, since health problems of the senior citizen were totally ignored at the First Hawaii Conference on Aging, held in Honolulu in 1954. Largely as a result of that conference, however, Honolulu is soon to have the Punchbowl Home for low-income and the Pohai Hale Nani Home for the higher-income elderly, the former a public housing and the latter a private enterprise under auspices of the Methodist church.

Master Plan a Need

Perhaps the greatest defect in Hawaii's health care structure is the *lack of a master plan* for the total care of the aged whose health needs revolve around a unified program for chronic diseases and disabilities. This need was pointed out in Hawaii almost ten years ago by various individuals but the warning fell on barren ground. The disturbance of the time, and the rush to organize against specific crippling conditions, probably were responsible. The Korean war had concerned everyone, many chronic diseases had no sponsor, and the doctors were too preoccupied with the threat of federal medicine in the form of the Murray-Dingell Bill. The net result was a myopic approach to problems of health at the expense of a more inclusive permanent plan of action.

A master plan for the prevention, care and control of chronic diseases and disability was clearly delineated by the Commission on Chronic Illness, which, after doing a good job, terminated its existence seven years after its birth in 1949. Such a plan revolves around early detection and early care, both in and out of hospitals, rehabilitation and prevention of chronic diseases and disabilities. It now remains for community leaders throughout the nation to carry out the various programs based on the individual needs of each community.

State Commission a Must

To implement and strengthen what has been done and further develop the program with facility and speed, a state body with authority is needed. State Commission on Chronic Illness and Aging has now existed in many states for a number of years. This should be a permanent commission consisting of proved, interested leaders with "know-how" in the community, well supported with adequate staff and funds.

Health is a necessary commodity of life, often more important than food and shelter. It is a community responsibility to develop and maintain the best possible health facilities and services. Partisan politics need not and should not enter here. A continued effort by dedicated leaders will lead to success.

Socialized Medicine a Menace

One of the ominous issues of the time is the possible acceptance of socialized medicine as an instrument of health care by the American public. In the heated atmosphere of the political arena in these pre-election months, the smoke is thick and there is much confusion. In a country which takes pride in democracy and individual freedom it is difficult to see how this question should arise.

To meet the immediate need of the relatively small group of the needy and the near-needy (4,500 at most) compulsory federal health insurance with far reaching serious consequences need not be forced on Hawaii's public. Many agree that federal medicine would abolish all voluntary health insurance plans and abolish the traditional doctor-patient relationship; it would lower the quality of medical care; and finally it would be costly to taxpayers. Coercive collectivism would only destroy individual freedom and deter future growth.

Develop Program at Community Level

Says James A. Shown, chairman of the Montana Medical Association Commission on Aging: "The negative attitude towards the facts of aging is the underlying pathology of the problem. All twenty areas listed in the White House Conference Guide on Aging revolve around mental health of the individual. These twenty areas may be considered the symptoms. We must treat these symptoms but will be successful only if the underlying disease is also recognized and treatment begun. The treatment is education, in a positive, decisive, and rational manner, beginning in grade school. Nearly all the needs of the aging citizens can be met and solved at a community level. Two dollars spent in a community on various programs for the aged will do the equivalent work of seven dollars taken from the community and sent on a round trip across the Potomac."

To develop programs to meet the health needs of the senior citizens, Hawaii's citizens and their leaders must shed all negative attitudes and settle down to work in a positive, objective manner. The challenge of positive health is big and broad. The road ahead is still long and winding, beset with hills and obstacles. To meet that challenge and win, a unity of action is necessary, and this is possible only if all the citizens of the 50th State remain unrestricted and free.

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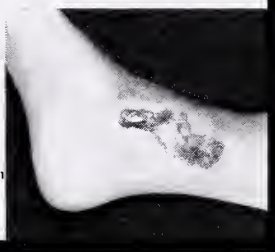
severe bruises ... swelling ... cleared by fifth day[2]





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INFLAMMATORY DERMATOSIS

rapidly spreading rhus dermatitis healed within a week[1]





INFECTED LACERATION

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THROMBOPHLEBITIS

back on his feet in a week after recurrent episode[1]





REFRACTORY CELLULITIS

normal routine resumed after 4 days of VARIDASE[1]



The President's Page



DR. CUSHNIE

I want at this time to say I certainly welcome the opportunity to serve the doctors of the Hawaii Medical Association. I hope that in solving the problems of legislation, contract medicine, insurance medicine, changing ideologies, and the responsibilities of the government to care for the indigent, the chronically ill, and the aged, we can preserve the ethics and principles of medicine which have so long served to enhance the prestige and promote the progress of medicine in the United States. I am certain the doctors realize we shall have to give as well as take, and change some of our adamant pursuit of individualism to more of an overall thinking and action, without sacrificing the principles we have always had in medicine.

The Senate Finance Committee deleted the proposal which would have extended compulsory Social Security coverage to some 150,000 self-employed physicians. The Senate Finance Committee was informed that the House of Delegates of the AMA had consistently opposed compulsory Social Security coverage for physicians. I doubt that the conclusions of the AMA represent the thinking of all the doctors. We may be fighting this battle a long time unless an alternative plan takes its place; namely HR 10, which would allow self-employed physicians, attorneys, etc., to establish tax-deferred pension plans. Unfortunately, this bill will probably be dead for this session before this is published.

The Anderson amendment to HR 12580, which would have financed a broad range of medical benefits for the aged under Social Security, was defeated. Senator Jacob J. Javits' amendment was also defeated. This would have given a broader Federal-state program of "preventive" care for the aged. Adopted instead was the Kerr amendment putting medical care provisions under the old age assistance program, which appears to be the best approach. According to the experts, this was a blow to the Kennedy-Johnson combine which wanted a broad Federal Social Security plan. We must give credit to Senator Hiram Fong for helping to defeat the Anderson amendment.

About twenty months ago a group of doctors were heralded as starting a new era in the practice of medicine in Hawaii—a better way, a sort of panacea to the quickening population increase, to help the financial status of the patients and to further the ideology of a few. Whether or not this problem can be worked out with those who pull the strings, I don't know but regardless of what happens, there is certain to be an end to one contract and a beginning of another. It is never-ending in that type of set-up. As you already have guessed, it's the Kaiser panel type of practice we are discussing.

It's a bit surprising, but not totally so, that the Nurses Association here in Hawaii endorsed their national association's fight for the inclusion of the care of the aged in the Forand Bill and similar legislation under the Social Security set-up. Evidently the relationship of the nursing and the medical professions needs some overhauling. Both professions are interested in attaining medical care for the aged but support widely divergent methods of attaining this care. It seems to me that the liaison between the associations has been poor, and no doubt the doctors must assume a great deal of the blame.



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[EDITORIALS]

Some Findings from the Hawaii Health Survey

The State Health Department recently released a report from the U.S. Public Health Service giving partial results of the Hawaii Health Survey conducted on Oahu from September, 1958, to October, 1959, as a joint project of local and federal agencies. Copies are available upon request. Additional reports are now being prepared by the local Office of Health Statistics.

Findings are based on a random sample of 3,300 households including 12,500 persons in the civilian non-institutional population of Oahu. Since the interview questionnaire and all procedures were identical with those used in the National Health Survey, comparable data for the mainland as a whole are available.

Acute Conditions

An acute condition was defined as any condition, other than a previously defined list of chronic conditions, which had lasted less than three months and for which the individual had seen a physician or had restricted his usual activity at least one day.

The incidence of acute conditions during the survey year was 274 cases per 100 persons on Oahu compared to 215 cases per 100 persons on the mainland. This difference was not entirely due to the higher proportion of children and young people in Hawaii. For each age group, except 65 and over, the Hawaii rate was higher.

The total number of acute conditions, as defined above, for the entire population of Oahu during the year was estimated at 1,264,000 or about three per person.

Respiratory disorders accounted for 60 per cent of all acute conditions. Injuries of all types constituted 13 per cent, digestive conditions 6 per cent, infectious and parasitic diseases 6 per cent, and the remainder (15 per cent) divided in lesser amounts among various ailments.

The rate for injuries involving motor vehicles was lower on Oahu than on the mainland, but for other types of accidents, such as in the home or at work, the rate was 20 per cent higher on Oahu. The incidence of respiratory conditions among adults was also noticeably higher on Oahu compared to the mainland. Otherwise, the pattern of acute conditions was similar in the two areas.

Chronic Conditions

Evidence of chronic conditions, as estimated from the survey, was limited by the fact that respondents reported only those conditions of which they were aware and which they were willing to report. The data are not comparable to those obtained from medical examinations where illness is detected through diagnostic tests and clinically significant symptoms.

The aggregate rate for all types of chronic conditions reported on Oahu was considerably lower than on the mainland. The proportion of the Oahu population reporting one or more chronic conditions of any kind was only 33 per cent compared to 41 per cent on the mainland.

To some extent, this difference is due to a younger population on Oahu, less subject to chronic ailments than the older mainland population. However, in all age groups tabulated after age 25, Oahu had a lower proportion of chronically ill persons. Under 25, proportions were about the same in both areas. This indicates that chronic disability is less prevalent here than on the mainland, regardless of the age factor.

Exceptions to the general finding of a lower

chronic disease rate on Oahu were higher rates for diabetes and asthma–hay fever. (For technical reasons, hay fever and asthma were lumped together.) There was more diabetes at the older ages and more asthma–hay fever at the younger ages on Oahu than at the corresponding ages on the mainland.

Other chronic conditions, such as heart disease, arthritis and rheumatism, various respiratory conditions, and physical impairments were less prevalent on Oahu. The prevalence rate for heart conditions was only 12 per 100 on the Island compared to 30 on the mainland. It is notable that heart conditions and high blood pressure were reported with almost equal frequency on the mainland, whereas on Oahu heart conditions were reported with only about half the frequency of high blood pressure.

The Oahu population had an estimated total of 5,380,700 days of restricted usual activity during the survey year due to chronic conditions. This averaged 12 days per person, but the average was higher for the youngest and oldest age groups and slightly higher for females than for males.

Physician Visits

The people of Oahu had a total of approximately 2,604,000 physician visits during the survey year. This included visits at the physician's office and also visits by the physician to the patient's home.

Physician visit was defined as consultation with a doctor of medicine or osteopathic physician in person or by telephone for examination, diagnosis, treatment, or advice. The visit was considered to be a physician visit if the service was provided directly by the doctor or by a nurse or other person acting under a doctor's supervision. A visit by the physician while a person was a hospital inpatient was not included, nor were visits made for services on a mass basis for a specific type of procedure, such as mass x-rays.

The average number of physician visits per person per year on Oahu was 5.6, contrasted to 4.8 on the mainland. Whether the higher rate on Oahu was due more to the nature and frequency of illnesses or to greater health consciousness in Hawaii will become clearer as additional data are extracted from tabulations concerning the seriousness of illness episodes.

About 61 per cent of all visits on Oahu were in the physician's office and only 1.5 per cent were made to the patient's home. Approximately one quarter of all visits were to hospital outpatient clinics. The remainder (about 13 per cent) were other types of visits, such as those to health units at place of work, health department clinics, and telephone consultations. This distribution is quite different from the mainland where 9 per cent of all visits were in the patient's home and only 9 per cent to outpatient clinics.

The proportions of visits in Hawaii by place varied with age. Only about half of the visits by children were to a physician's office, while substantial proportions were to hospital clinics and by telephone conversation. Persons in the middle-age groups were more likely than others to make office visits. Among older persons, the proportion of visits by the physician in the home was 6.9 per cent, compared to 1.5 per cent for all ages.

Males made 43 per cent of all visits and females 57 per cent. Females were more likely to visit hospital clinics and to have telephone consultations, while males were those most likely to visit company health units.

A great deal of additional information will be available from survey tabulations on physician services, such as the distribution of visits by category of service, time interval since individuals last saw a physician, the amount of medical care received by different racial groups, and specific conditions for which a physician was or was not consulted.

CHARLES G. BENNETT
Office of Health Statistics
Department of Health

Medical Care for the Elderly

Representative Forand, though a sort of Wrong Way Corrigan in the health plan field, did at least manage to call a lot of attention to the problem of financing health care for the senior citizen. Several acres of newsprint have been filled with accounts of plans and proposals, measures and countermeasures; state conferences on aging have been held in preparation for next year's White House Conference on Aging; and medical journals have been editorializing on the subject.

California Medicine, in an editorial in its June issue, points out that the gibe "All right, if I'm wrong, let's see you come up with a better plan" is unfair and illogical; it overlooks the possibility that the whole philosophy of the original plan may have been wrong, and a different approach may be in order.

The A.M.A. summarized the problem in an eight-point series of statements, commented upon in *Northwest Medicine's* June issue. Basic in its

view is a revised attitude toward compulsory retirement. *Northwest Medicine* reiterates California's view in a quote from Allan Kline of the Farm Bureau Federation: "If you can do it yourself, you had better do it yourself and not let the government do it. If government must do it, you had better let state or local government do it. You can see them better."

Michigan's *Journal* also places editorial emphasis on promoting as much self-dependence as possible for the elderly, by encouraging more job opportunities for them. And the *Rocky Mountain Medical Journal* warns, similarly, against the assumption that the answer to the problem demands a long further step toward the welfare state.

Passed on August 29 was HR 12580, with coverage limited to the near-needy minority of elder citizens. It was opposed—mysteriously—as inadequate. Much of this opposition came from sources dedicated to extension of social security and ultimate national compulsory health "insurance," and was therefore worse than suspect.

The Mills Bill, with roughly 50 per cent participation by states, will cover from one-half to one million needy persons over 65 years of age. It would not spend money needlessly on those already financially secure, or covered by voluntary health insurance, or otherwise protected. It would cover the needs of the others, on a voluntary, free-choice-of-physician basis.

The Generic Name Fallacy

Drugs by "generic" names—acetylsalicylic acid instead of Aspirin; phenobarbital instead of Luminal; prednisolone instead of Meticortelone—are apt to cost less than the same drug under a copyrighted proprietary name, since as a rule anyone can manufacture them, and competition is unrestrained.

Doctors have known this for years, but the Kefauver committee, which has been investigating the drug business, has just found it out and is all excited over the discovery of a solution to the current high cost of drugs.

It's a specious solution—it looks sensible, but it won't stand up under close inspection. In the first place, a drug under a brand name carries with it a guarantee of purity and correctness of dose that is as reliable as the reputation of the company that makes it. The only assurance of quality you get with a drug bought under a generic name comes from such supervision as the U.S. Food and Drug Administration can carry out, which is spotty at best.

Add this uncertainty of supervision of quality to the dog-eat-dog competition that is inevitable among multiple small firms, and you have a potentially dangerous situation that lowered costs cannot justify.

There's another objection. The reason pharmaceutical firms have been able to afford the stupendous cost of research into improved steroids and antibiotics is very simple. And it isn't just humanitarian motives. It's the American profit motive. They've been able to anticipate paying off the cost by marketing a product under a copyrighted name.

If a firm had to sell such a product in direct competition with everyone who cared to make it —and in competition with firms that had not already spent millions in developing it—it would never have been able to justify the original research in the first place. Two major American drug firms have recently abandoned research in the agricultural insecticide field for this very reason.

So the question is hardly more complex than this: would you as a physician settle for sulfanilamide or sulfathiazole, at a few cents a tablet, instead of Achromycin or Panmycin or Ilotycin at ten times the price—with no need for any qualms about the purity or the amount in each capsule? Would you willingly return to cortisone, in tablets of slightly dubious purity and dose size, just to save your patient from having to pay a share of what it cost to develop Aristocort and Kenacort and Medrol and Decadron?

Actually there are few of these modern, so-called expensive drugs which do not, if prescribed with prudence, afford the patient a good chance of being saved far more than their cost in terms of diminished disability and discomfort, shortened illness, and lower risk of mortality. A return to horse-and-buggy prices would mean a return to horse-and-buggy medical practice. Trademarks, in the pharmaceutical business, are worth every cent they cost.

Infant Death Case Study No. 8

A male infant was born at 38 weeks' gestation, with weight of 5 lb., to a 19-year-old Filipino-Hawaiian primigravida, whose medical history and STS were negative, and who was Rh positive. She was first seen during her second trimester, and following that visit had German measles. There was one visit during the second trimester, and four during the third. Weight gain was 50 lbs. During her 34th week she was hospitalized for toxemia; at that time her BP was 170/111, albumin 3-4+, and edema 3-4+. There was no headache, dizziness, or blurring of vision. No discharge date was given for this admission, and there is no record of treatment between this time and the time of delivery.

She was re-admitted at 38 weeks at 4:30 P.M. and at 5:00 P.M. was given 2 cc of magnesium sulfate 50%. Four more doses were given two hours apart. Labor lasted 13 hours. Membranes ruptured at 12:43 A.M. and the baby was born at 1:21 A.M. She was given Demerol 100 mgm and Phenergan 25 mgm one hour prior to delivery. Presentation was cephalic with a RML episiotomy; delivery was spontaneous; placenta and membranes normal.

The infant appeared normal at birth; respirations were spontaneous, cry lusty, and color good. The only resuscitation given was oxygen. The baby was placed in an incubator and kept on his side with oxygen 2-5 L/min. At 11:00 P.M. (approximately 22 hours of age), his condition changed after feeding, and he was noted to be pale, with grunting respirations and markedly distended abdomen. There were spastic movements of his extremities and the next day he had a convulsion. Feedings were continued throughout this period. He was given water after birth, and "SMA" formula begun at 24 hours.

At the time his condition changed he was given Nalline 2 mgm and oxygen was continued. There is no record of management during the second day of life except for oxygen and "SMA" feedings. On the third day he was given vitamin K 20 mgm and Coramine 1cc IM. Six hours prior to death positive pressure was started (mm not recorded) with an airway and there was slight improvement for about 15 minutes. The infant expired at 11:10 A.M. on the third day of life.

Discussion: The initial episode of difficulty occurred at 22 hours after birth following a feeding which suggested aspiration. Following the sudden onset of difficulty, manifested by pallor, dyspnea and convulsions, milk feedings were continued. It was felt that in view of the rather marked respiratory difficulty this was not a safe procedure. The point was also brought up that in small infants it is not always desirable to start feedings early and oral liquids can be delayed quite safely in these babies.

The group felt that the drugs used in attempts to treat this child were not appropriate by all information available in the protocol; also, doses were excessive. Nalline was given 22 hours after birth; no indication for this drug was present at this time and the dose was excessive. Under the circumstances this drug acts as a sedative and would be undesirable in an infant with respiratory distress who is already depressed. Vitamin K was also given in an excessive amount, without any specific indication from the history available. There was much discussion about the use of Coramine, and it was generally felt that this drug is much too dangerous to be used routinely in attempts at resuscitation. It certainly is contraindicated in a patient who is having convulsions.

Classification: This case was classified as an obstetrical and pediatric death, preventable from a practical standpoint. The specific factors of prevention were:

1. Improper prenatal care.
2. Excessive weight gain.
3. Excessive sedation to the mother (100 mgm of Demerol).

It was felt that both the patient and physician were responsible for these conditions. Pediatric factors of prevention included a small baby being started too early on feeding, and injudicious use of drugs.

One of a series of case reports prepared by the Advisory Committee to the Bureau of Maternal and Child Health to illustrate the type of study made in the instance of an infant or maternal death in Hawaii.

This is What's New!

School phobia, which differs from truancy, is usually due to a hostile, exaggerated **dependency** between a youngster and one of the parents. The treatment requires neither too much anger nor too much sympathy, as well as disconnecting the television set and elimination of other **secondary gains** achieved by the child's remaining at home. (*Postgrad. Med.* [Feb.] 1960.)

* * *

Myotonia congenita, sometimes called Thomsen's disease, after the physician who first described the signs and symptoms in himself, has been treated by **depletion of body potassium** with chlorothiazide and cortisone. The disease, which results in "slow motion" contraction and relaxation of all skeletal muscles, appeared to respond better to the potassium depletion than to quinine or other medications. (*South African Med. J.* 33: 984-86, 1960.)

* * *

Hematologists from Salt Lake City report on the clinical management of **leukemia** by the use of **chemotherapy, whole blood transfusions and antibiotics.** They report the following: Acute lymphoblastic leukemia, remissions fairly common and average life span increased twofold; acute myeloblastic leukemia, full remissions extremely rare and prolongation of life infrequent; chronic myelocytic leukemia, full remissions common but prolongation of life uncommon; and chronic lymphocytic leukemia, remissions incomplete but longevity greater than myelocytic leukemia. (*Am. J. Med.* [May] 1960.) [An excellent symposium on leukemia.]

* * *

Hypophysectomy for **metastatic carcinoma of the breast** is reported in 343 patients. Less than half obtained remissions and of these only 21 obtained true arrests of their carcinomatous lesions. The others experienced regressions. The surgeons recommend hypophysectomy as the initial treatment in postmenopausal patients as well as those who have had previously favorable response to bilateral oophorectomy. (*Am. J. Surg.* [April] 1960.)

* * *

Routine testing of thyroid function in 33 **alcoholics** revealed 21 of them to be **thyroid deficient.** Fifteen of the alcoholics found less need for alcohol often with total curtailment of their drinking when thyroid replacement was instituted. (*J. Clin. Endocrinol.* [April] 1960).

Two Philadelphia physicians report on the thankless job of **disability evaluation** in 1,000 Civil Service workers. They found that 60 per cent of all applicants requested physical disability retirement rather than retirement because of age or service to their country. Frustrating was evaluation of "subjective disability." Their looking this up in Gould's medical dictionary did not help the situation because subjective is defined as "experienced by the individual himself and not amenable to physical evaluation." As of last year, the annual cost of the retirement program was greater than $519,000,000. (*A.M.A. Arch. Ind. Health* [May] 1960.)

* * *

The Russians have converted the **heart** into an **abdominal organ** in the treatment of **coronary disease.** The surgeon, reasoning that the negative intrathoracic pressure causes additional work for the heart, surrounds the heart by positive pressure by connecting the pericardium to the peritoneal cavity by an opening through the diaphragm. (*Khirurgiya* [March] 1960.)

* * *

A psychiatrist reviews the problems of **contemporary psychoanalytical training.** Among his major conclusions and recommendations: (1) "To define psychoanalysis as a special branch of medicine is scientifically unsatisfactory." (2) The psychoanalyst's pledge is "morally offensive and should be abolished." And finally the structure of the training analyst as presently conceived interferes with both the candidate's personal analysis and his learning how to analyze. (*A.M.A. Arch. Gen. Psychiatry* [July] 1960.)

* * *

Reports on variations of the **Munchausen's syndrome** (named after the famed liar Baron von Munchausen) continued to crop up in the British literature. The latest is a patient with a history of chest pain and many physical findings mimicking **myocardial infarction.** The patient afflicted with the Munchausen syndrome relates his symptoms so plausibly that even the most skilled physician has difficulty in recognizing that he is dealing with the Munchausen syndrome rather than organic disease. The experts in the syndrome believes that it differs from malingering or exhibitionism. (*Brit. Med. J.* [Mar. 5] 1960.)

FRED I. GILBERT, JR., M.D.

THE DANGER OF SOCIALIZED MEDICINE

Is a very real one. However, as long as people can continue to adequately finance their own medical care through voluntary, pre-payment plans there will be little excuse for government interference in this area.

An ever present danger, which could weaken a pre-payment plan from within and open the flood gates of socialized medicine, is UNNECESSARY UTILIZATIONS OF BENEFITS. Physicians, hospitals and members by helping fight the UNNECESSARY UTILIZATION problem are in a very real sense fighting Socialized Medicine.



HAWAII MEDICAL SERVICE ASSOCIATION

A Non-Profit Community Service Organization for Prepaid Health Care

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In Memoriam-Doctors of Hawaii-XXVIII

This is the twenty-eighth installment of In Memoriam—Doctors of Hawaii.

Harry Triebner Hollmann

Harry Triebner Hollmann was born in Philadelphia, Pennsylvania, on December 13, 1878, the son of Harry and Mary (Thomas) Hollmann.

His early education was received in the public schools of Philadelphia. He attended Temple University, Philadelphia, and the Medico-Chirurgical College (now a part of the University of Pennsylvania) which granted him his medical degree in 1898.

In 1900 he married Amelia Duncalfe at Richmond, Kentucky. The couple had three children, Bonita, Pamela Jane and Harry.

Dr. Hollmann was instructor in pathology and bacteriology at the Medico-Chirurgical College from 1898 to 1906. He was physician to the Bureau of Health in Philadelphia, 1903-06. From 1905-06 he was visiting ear, nose, and throat surgeon at the Philadelphia General Hospital.

Dr. Hollmann was internationally recognized as an authority on leprosy and was credited with having originated treatment with the ethyl ester extracts of chaulmoogra oil. Due to his interest in leprosy, Dr. Hollmann was appointed assistant superintendent of Kalaupapa leprosy settlement on the Island of Molokai in 1906. The following year he was transferred to the United States Leprosy Investigation Station, Honolulu. Dr. Hollmann was one of the first scientists to claim success in growing the leprosy bacillus, and was the first to cultivate the bacillus of rat leprosy. He also wrote many articles on leprosy and skin diseases which were published by the U. S. Public Health Service. In 1917 and 1918 Dr. Hollmann was director of the Leprosy Investigation Station and medical superintendent of the Kalihi Hospital.

Later he resigned to become superintendent of The Queen's Hospital for one year, following which he entered private practice in Honolulu, specializing in dermatology and urology.

Dr. Hollmann was prominent in local politics as a member of the Democratic party.

He was a member of the Hawaii Medical Society, past District Deputy Grand Sire I. O. O. F. for Hawaii; past Chief Patriarch, Polynesian Encampment, I. O. O. F.; Past Worthy Patron, Lei Aloha Chapter, O. E. S.; a 32d degree Mason; Shriner; honorary member of the Sons and Daughters of Hawaiian Warriors; Chairman of the Territorial Radio Commission; and a member of the Honolulu Golf Club.

Dr. Hollmann died in Honolulu on December 13, 1942, at the age of 64.

Frank Woodland Taylor

Frank Woodland Taylor, born in 1871, was granted a medical degree in 1900 from Dalhousie University Faculty of Medicine, Halifax, Nova Scotia.

Dr. Taylor came to the Islands in 1905. He was physician for the Hamakua Mill Company and lived at Paauilo, Hawaii. He also served as government physician for many years. The doctor was a resident of the Big Island until 1916 or 1917. By 1923 he had located in Oakland, California, where he practiced until his retirement.

Dr. Taylor died January 2, 1936, in Oakland at the age of 64. He was a former member of the Hawaii Medical Society.

John Harrison Bemiss

John Harrison Bemiss was born in Louisville, Kentucky, in 1856, the son of Dr. Samuel Merrifield and Frances (Lockert) Bemiss. His father was Professor of the Practice of Medicine and Clinical Medicine at the University of Louisiana.

He entered the University of Virginia at the age of 15, and graduated in 1876, following which he took his medical training at the University of Louisiana (now Tulane) at New Orleans.

Having been in frail health since birth, Dr. Bemiss accepted an appointment as government physician in the Wailuku and Lahaina districts on Maui in the hope that the climate would prove beneficial. Dr. Bemiss arrived in Honolulu March 26, 1878, aboard the "City of New York," and soon left for Maui, where he practiced for five years. Shortly after his arrival he became associated with Dr. Frank H. Enders of Wailuku. Dr. Bemiss was especially interested in leprosy and prepared several papers on the subject.

In August, 1882, Dr. Bemiss left the Islands to return to New Orleans. He went into partnership with his father in the practice of medicine and also became his assistant in the hospitals and at the University of Louisiana. In collaboration with Dr. G. B. Underhill and Dr. F. W. Parham he organized the first quiz classes in the medical department. When the New Orleans Polyclinic was reorganized on an entirely clinical basis in 1887, Dr. Bemiss became the first president and occupied the chair of Physical Diagnosis.

Dr. Parkham, writing after Dr. Bemiss' death, said: "It was no secret among his students that the chair of physical diagnosis was the most ably filled and the most sought after in the whole Polyclinic. He had a happy knack with students, encouraging them on from one step to another, guiding them, making them fully appreciate each explanation so thoroughly that it was a pleasure to go on. His attention to details, in his teaching at least, was unusual, and to this his success as a teacher was largely due."

Dr. Bemiss was the author of a number of papers published in the New Orleans *Medical and Surgical Journal* and for years was one of the editors of the *Medical News*.

He was passionately fond of music, poetry, and children.

In 1897 his health failed and he went to Ocean Springs, Mississippi, for a rest. He arrived during an epidemic of yellow fever and ignored his own condition to help the overworked physicians battle the epidemic. As a result of his self-sacrifice, Dr. Bemiss died on September 2, 1897, at the age of 41.

Hawaii Medical Association

MINUTES OF THE COUNCIL MEETING

August 16, 1960 at 6:30 p.m.
Oahu Country Club, Honolulu

PRESENT

Dr. Edward F. Cushnie, presiding; Drs. Benson, Burden, Fleming, Giles, Nishijima, and West, plus guests Drs. Harry L. Arnold, Jr., and H. Q. Pang.

MINUTES

The minutes of the March 4, 1960, meeting were approved as published.

MEDICARE CONTRACT FOR 1960-61

The contract with the Office for Dependents' Medical Care will expire August 31, 1960. The Federal Medical Services Committee recommended approval of a one-year extension of the present contract.

ACTION:

It was voted that we accept the recommendation of the Federal Medical Services Committee and authorize the President to sign the contract.

CORRESPONDENCE FROM HONOLULU COUNTY MEDICAL SOCIETY

As directed by the Council, the President initiated correspondence with the Honolulu County Medical Society. The Society advised that their Finance Committee would cooperate with the Hawaii Medical Association to work out a salary schedule: the matter of conducting a survey to determine the amount of time member doctors contribute to various causes had been turned over to their Public Service Committee; and that the Board of Governors' agenda and minutes are open to review by any member of the Society.

SCHOOL HEALTH ACTIVITIES

It was noted that for the past several years the HMA has been listed in an AMA publication as considering establishing an advisory committee for liaison purposes with the Department of Public Instruction.

ACTION:

It was voted that the President appoint a committee of three to investigate the advisability of establishing a liaison committee with the Department of Public Instruction and report back to the Council.

DIABETES COMMITTEE

The Diabetes Committee wants to offer blood sugar tests during Diabetes Detection Week. They plan to utilize the Department of Health's Clinitron for this purpose. The question arose whether people would go to a certain spot at a designated time. This was followed by a discussion comparing the merits of urinalysis and blood sugar testing. The project itself was felt to be good public relations and worthwhile health education and that the committee should be encouraged. Since figures estimating the total cost were not available, the Council questions whether it was in a position to authorize a specific expenditure for the project.

ACTION:

It was voted that the President get in touch with the Chairman of the Diabetes Committee for more details which are to be circulated to the Council for further action.

REHABILITATION PROJECT

Dr. Nishigaya was asked to report to the Council on the findings of the Chronic Illness & Aging Committee relative to the proposed project for the rehabilitation of the chronically ill in a general hospital and in nursing homes. He told of the recommendations that were developed from the Governor's Conference on Aging. The Committee supports the principle of team approach under the supervision of the attending physician. It is designed to follow through from the hospital to the home. The Division of Rehabilitation has been granted a sum of money by the Federal Government for a pilot study. He pointed out that this is not an indigent program and it does not come under the Department of Social Services. It will be controlled by practising physicians. Dr. Burden wondered if the work of the Rehabilitation Center could be extended to take care of this project and was told that Dr. Shepard is far too busy to take on such a project. The head physician, and perhaps the team, will be paid from the grant.

ACTION:

It was voted to approve of this project provided that it is under the control of the physicians, and to leave it in the hands of the Chronic Illness and Aging Committee.

PROTOCOL COMMITTEE FOR DIGNITARIES

During Dr. Orr's visit in the spring it was suggested that perhaps a committee should be established to take over the responsibilities of entertaining dignitaries who visit in Hawaii. A discussion on the advisability of establishing a standing committee for this function took place.

ACTION:

It was voted that the matter of entertaining dignitaries should be left to the discretion of the President, with the assistance of the officers.

EMPLOYMENT OF PHYSICALLY HANDICAPPED AWARD

A discussion on whether or not there is anyone in Hawaii who would qualify for the award took place. It was felt that most physicians refer the matter to the Division of Rehabilitation and the State usually tries to find employment for the handicapped. Dr. Cushnie was instructed to check with Dr. Shepard and the Bureau for Sight Conservation to determine if there is anyone in Hawaii who has put forth special effort in this field.

SELECTION OF OUTSTANDING PHYSICIAN

Postgraduate Medicine plans to publish the biography of one outstanding physician of each state in a series of articles. The names of Drs. McGrew, Hillebrand, and Gerritt Judd were among those mentioned as possibilities. It was felt that Mrs. Robert Katsuki could be most helpful in making the selection.

ACTION:

It was voted that a committee be appointed to select a deceased physician whose biography would be published in *Postgraduate Medicine*.

POLITICAL ACTION

A lengthy discussion emphasizing the importance of active political interest by doctors took place. The hope was expressed that the doctors might organize on a state level. It was felt that an outside political organization

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Book Reviews

★Communicable and Infectious Diseases, 4th Ed.

Edited by Franklin H. Top, A.B., M.D., M.P.H., F.A.C.P., F.A.A.P., F.A.P.H.A., 768 pages, $20.00, The C. V. Mosby Company.

This is an excellent text. Dr. Top has obtained the services of 21 highly authoritative collaborators and put the material together in a well written, nicely organized fashion. The text is well indexed and amply illustrated with photographs, tables, and graphs, the latter two, however, being sometimes a bit difficult to interpret. The diseases of bacterial, viral, and rickettsial etiology and to a more limited degree, the more common mycotic and parasitic diseases are well covered, with up-to-date information. There are good introductory chapters on epidemiology, immunology, and the practical aspects of hospital care of patients with infections and communicable diseases.

There is an excellent chapter on chemotherapeutic and antibiotic agents by Dr. Mark H. Lepper. This particular chapter can be highly recommended to any physician using these agents and it alone would justify having this book on your reference shelf.

JOHN R. STEPHENSON, M.D.

Modern Nutrition in Health and Disease, 2nd Ed.

Edited by Robert S. Goodhart, M.D., and Michael G. Wohl, M.D., 1152 pp., $18.50, Lea & Febiger, 1960.

A comprehensive book on a too often taken for granted subject. Besides the usual topics one usually expects to encounter in such a book, it contains chapters on such facets as antimetabolites, the relation of diet to oxidative enzymes, chemical and other additives to food, and psychology of appetite.

The simple style and bold type are conducive to quick perusal and understanding of current concepts and theories of nutrition. A worthwhile review and reevaluation of personal knowledge of nutrition for any physician.

STANLEY E. KOBASHIGAWA, M.D.

★Textbook of Otolaryngology

By David D. DeWeese, M.D., and William H. Saunders, M.D., 464 pp., $8.75, The C. V. Mosby Co., 1960.

This book accomplishes its purpose of providing, for medical students and general practitioners, concise information on diagnosis and management of disease of the nose, throat, and ears. In addition, there are excellent chapters on speech development and therapy, rehabilitation of the deaf, and diseases of the salivary glands.

The book is simply and directly written, with emphasis on practical rather than theoretical aspects. Sufficient detailed information is always given to guide the family physician in the management of the patient who does not really need the specialist's care. The book is highly recommended.

DONALD M. WRIGHT, M.D.

★ means highly recommended.

Medical Care of the Adolescent

By J. Roswell Gallagher, M.D., 384 pp., $10.00, Appleton-Century-Crofts, 1960.

This work is the first compilation of our present knowledge of the adolescent years, a long-neglected (medically speaking) period of life.

The author, a pioneer in his field, has established the first clinic devoted to the study of adolescence in this country. He has gathered about him a team of specialists, all leaders in their particular specialties, who were chosen because of their mutual interest in the problems of the adolescent. They have compiled a considerable knowledge of these problems and now, after eight years, Dr. Gallagher has seen fit to set it down in print.

The book is full of well-integrated common sense and emphasizes the human approach to handling the patient as a person and not as a disease.

The book deals not only with the ills afflicting the adolescent but also particularly with the physician's approach to the adolescent patient and how to treat him successfully.

Standards of normal growth and development are given in detail and both organic and emotional conditions are covered with many pointers on diagnosis and treatment.

It is highly recommended for any physician dealing with "teen-agers": general practitioners, pediatricians, school physicians, public health workers—all who are concerned with the welfare of the adolescent.

DONALD C. MARSHALL, M.D.

★Essentials of Orthopedics, 3rd Ed.

By Philip Wiles, M.S., F.R.C.S., F.A.C.S., 576 pp., $13.00, Little Brown & Co., 1960.

This interesting and practical synopsis of orthopedics both from the medical and surgical aspects will be extremely well received. Although it is a text book, Dr. Wiles has permeated the pages with his own personal remarks and a pleasant literary style that reminds one of its British origin. The chapters on posture and its relation to orthopedic disease would profit anyone to read. Some of the now accepted forms of joint manipulation are excellently illustrated and clearly presented. The majority of x-rays presented clearly display the intended pathology. The clinical photographs are very well executed. Dr. Wiles has appended a reference section which includes the majority of the classical articles on the diseases in question, as well as some of the most recent efforts. All in all, there is very little chaff in this well-condensed yet amazingly complete 550 pages of text and illustrations. This book is very highly recommended for those interested in orthopedics either full or part-time.

ROWLIN L. LICHTER, M.D.

Manual of Tropical Medicine, 3rd Ed.

By George W. Hunter, III, Ph.D., Col. U.S.A. (Ret.) 892 pp., $15.00, W. B. Saunders, 1960.

The third edition of this now classic text of tropical medicine is most comprehensive. There are 33 collab-

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County Society Reports

Hawaii

The April (1960) meeting of the Hawaii County Medical Society was held on the 25th at the Naniloa Hotel. Guests present were Dr. Ivar J. Larsen, Mr. C. R. Newton, Mr. and Mrs. Clyde Crawford, Mr. and Mrs. L. Warsh, and five students from the local schools —Mr. Leroy Andrews, Juergen Dennecke, Leslie Correa, Richard Cook, and Margo Victorine.

After the guests were introduced, Dr. Hata announced the winners of the essay contest sponsored by the American Association of Physicians and Surgeons and the Hawaii County Medical Society. Judges of the contest were Mr. Clyde Crawford, Mr. L. Warsh, and Dr. Robert Miyamoto, First prize (a tie) $30.00 each went to Mr. Leroy Andrews and Juergen Dennecke, second prize ($20.00) went to Leslie Correa, third prize ($10.00) went to Mr. Richard Cook, and fourth prize ($10.00) went to Miss Margo Victorine. In the State finals, Mr. Leslie Correa placed second, and Mr. Juergen Dennecke third.

Dr. Hata stated that the Hawaii County Medical Society played an important role in helping to pass Senate Bill 38 at the last legislative session in which $175,000 was appropriated for Mabel Smyth Library.

Following the business session. Dr. Larsen gave an instructive talk on "Recent Concepts and Principles of Amputations." Mr. Newton demonstrated the different types of orthopedic appliances used by the amputees.

* * *

The Hawaii County Medical Society held their monthly meeting on May 27, 1960, at the Hilo Hotel. HMSA acted as host at a delicious steak dinner. There was a record attendance of the doctors.

The meeting was called to order by President Richard Hata at 8:15 P.M. Reading of the minutes of the previous meeting was dismissed, and current business matters were taken up. A letter was received from the local Japanese Chamber of Commerce requesting contribution to the Kapoho Relief Fund. Since many of the doctors had already made individual donations, it was thought that contribution from the Society was not necessary. Dr. Mitchell made the motion to this effect and was seconded by Dr. Miyamoto. The motion was carried.

Dr. Mizuire suggested that the Society set up a scholarship fund for worthy students entering college. He explained that such a fund would help to bring a better understanding between the local populace and the Medical Society. No definite action was taken.

Following the business meeting, Mr. Veltmann, Mr. Yuen, Mr. Oliphant, and Dr. Sakimoto spoke in behalf of HMSA. Dr. Bergin made an urgent request to change the fee schedule in order to benefit the general practitioners, for in the past, he felt that the fee schedule favored primarily the specialists.

* * *

The Hawaii County Medical Society held its monthly meeting on June 29, 1960, at the Naniloa Hotel. The meeting was called to order by President Richard Hata at 7:45 P.M. Dr. T. Kutsunai, a delegate of the recent Hawaii Medical Association meeting held in Honolulu, made a detailed report.

Following the business meeting, Dr. Cloward enlightened the members of the Society with a talk on "Diagnosis and Treatment of Lesions of the Cervical Spine by Diskography and Vertebral Body Fusion."

The meeting was adjourned at 10:45 P.M.

TOKUSO TANIGUCHI, M.D.
Secretary

Honolulu

The Honolulu County Medical Society met on Tuesday, April 5, 1960 in Mabel Smyth Auditorium.

Presentation was made of awards to winners in the 1960 AAPS Essay Contest, Honolulu County Division: 1st to Mr. Ronald Hayashida ($75.00 in Securities), 2nd to Mr. Gerald Sumida ($35.00 in Securities), and 3rd to Miss Lucille Ching ($20.00 in Securities).

A discussion on "Why Indigent Medical Care in the Department of Social Services" was presented by Miss Mary Noonan, Director of Department of Social Services; and Mr. Francis Ishida, who spoke in place of Mr. Morris Fox, Administrator, Division of Social Welfare.

The meeting was called to order by President H. Q. Pang at 7:45 P.M. Approximately 85 members and guests were present.

Dr. George R. Schneider and Dr. John R. Watson, new active members, were acknowledged. Neither one was present.

Dr. Pang announced that the Medical Society's petition for a Charter of Incorporation was filed in the Treasurer's office on February 18, 1960, and was granted on March 14, 1960, and that the Society has 30 days in which to complete its organization from an unincorporated association to a nonprofit corporation. He stated that in order to make things legal, several things have to be done, including the adoption of the bylaws for this nonprofit corporation and the approval of several resolutions by the membership. Mr. Thomas V. Rice, the Society's attorney, was present to explain the Charter of Incorporation in general and to answer questions. Amendments to the Charter were suggested, but it was explained that no changes can be made at this time since the Charter has been granted as circulated and that any amendments hereafter, either of the Charter or Bylaws, have to follow the amendment procedures of the Charter or Bylaws.

Dr. Mason, Chairman of the Constitution and Bylaws Committee, then read the following resolutions:

Resolution #1

Resolved, that the Honolulu County Medical Society, an unincorporated association, in consideration of the assumption by Honolulu County Medical Society, a Hawaii nonprofit corporation, of any and all of the debts and liabilities of the said unincorporated association as of this 5th day of April, 1960, shall and does hereby grant, bargain, sell, transfer, and deliver unto said Honolulu County Medical Society, a Hawaii nonprofit corporation, all of its right, title and interest in and to all property, rights, franchises and privileges of every kind and description, real, personal, or mixed, and wheresoever situated, subject, however, to all debts, obligations, and liabilities of this Honolulu County Medical Society, an unincorporated association; and be it further

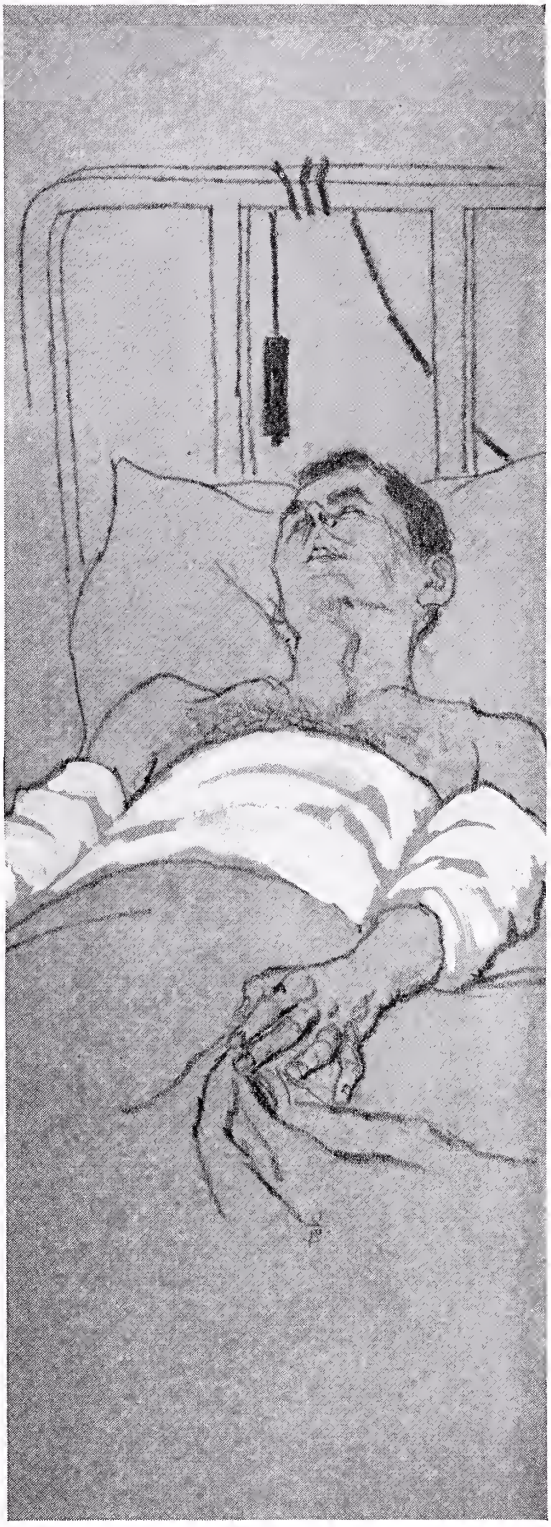
Resolved, that the President and the Secretary, or the Treasurer, shall be and and they hereby are au-

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1. Eisen, H. N., and Tabachnick, M.: Protein Metabolism, M. Clin. North America 39:863 (May) 1955. 2. Jamison, R. M.: General Nutritive Deficiency, Virginia M. Month. 83:67 (Feb.) 1956. 3. Goldfarb, A. F.; Napp, E. E.; Stone, M. L.; Zuckerman, M. B., and Simon, J.: The Anabolic Effects of Norethandrolone, a 19-Nortestosterone Derivative, Obst. & Gynec. 11:454 (April) 1958. 4. Batson, R.: Investigator's Report, Feb. 11, 1956. 5. Weston, R. E.; Isaacs, M. C.; Rosenblum, R.; Gibbons, D. M., and Grossman, J.: Metabolic Effects of an Anabolic Steroid, 17-Alpha-Ethyl-17-Hydroxy-Norandrostenone, in Human Subjects, J. Clin. Invest. 35:744 (June) 1956. 6. Brown, C. H.: The Treatment of Acute and Chronic Ulcerative Colitis, Am. Pract. & Digest Treat. 9:405 (March) 1958.

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HAWAII MEDICAL ASSOCIATION

(Continued from page 66)

would not conflict with the aims of an association of the professions.

ACTION:

It was voted that the Council be in sympathy with a political action committee and it is left to the individual doctor to go ahead and do as he pleases. The Council encourages political activity on an individual basis.

TREASURER'S REPORT

Dr. Giles reviewed the over-all finances for the first seven months and the financial outcome of the 1960 annual meeting. The auditor's comments in relation to the handling of members' dues, purchase of office equipment, and expenditures for postage were noted. It was noted that the revision of the bylaws will eliminate most of the problems connected with dues and that the postage expenditures have been reduced through use of various types of postage permits. The Executive Secretary was directed to observe the auditor's recommendations with reference to purchases of office equipment.

A discussion followed on how to implement the House of Delegates' mandate to add $5.00 to the annual dues to cover the activities of the Woman's Auxiliary. It was decided that the treasurers of the county societies are to be advised that the annual dues for 1961 will be $40.00 for each active member and that $5.00 of this amount will be transmitted to the Woman's Auxiliary as collected and without regard to the individual member's status; that is, whether it be a woman doctor, an unmarried doctor, etc. It was noted that the work of the Woman's Auxiliary benefits all the members. The dues for the county auxiliaries will be handled in the manner prescribed by the individual counties except that they will no longer be required to transmit part of their dues to the state and national organizations.

The financing of delegates' trips to the White House Conference on Aging was discussed. The Council was advised that Dr. Yamauchi had been selected as an official delegate from Hawaii but that he was the only physician in the delegation. The Commission will received Federal funds to send perhaps three of the delegates to the Conference and that funds will be solicited from the community to cover the expenses of the other eight delegates. Dr. Nishigaya felt that a letter should be addressed to the Commission on Aging asking that we be given official permission to send a physician at our own expense. Dr. Cushnie spoke of the importance of getting physicians included in the make-up of the official delegations, and the difficulties the HMA had experienced in accomplishing this. The question was raised on how much could be done by a physician who was not an official delegate. Dr. Nishigaya said that from his experiences in attending pre-conference meetings on the mainland, a great deal could be gained. The possibility that the Commission may not be able to raise the money for all the delegates was mentioned. Dr. Cushnie was asked to get in touch with Dr. Komuro to determine whether or not we could send an additional delegate if we assumed the financial responsibility for his trip.

Dr. Giles brought the Council up to date on the activities relating to the Physicians' Benevolent Fund. He read a letter he had received from Dr. Boyden on this subject. It was felt that any changes in the make-up of

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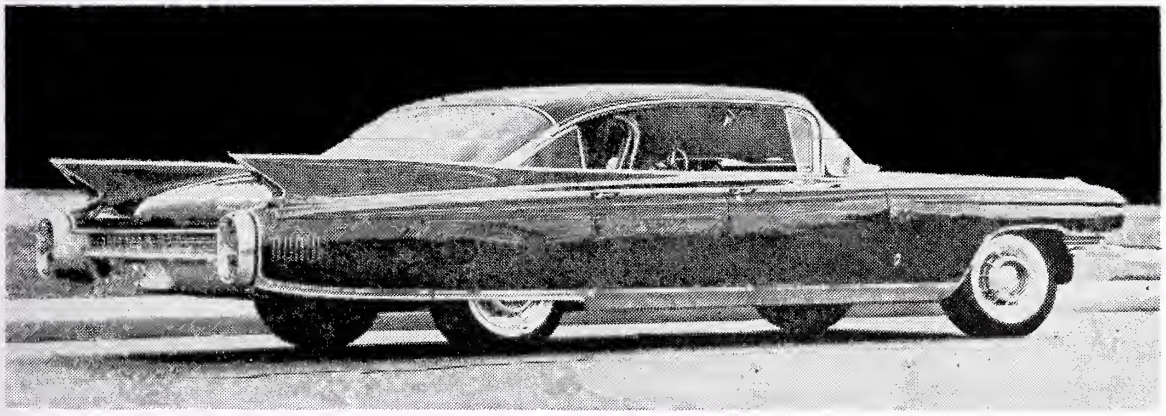


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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, State of Hawaii

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KATSUKO ENOKI, *Associate Editor*
HAZEL KIM, *Associate Editor*
MILDRED KIM, *Associate Editor*

OLIVE C. PRIDGEN, *Executive Secretary*

Hawaii Nurses Association Convention

Dates: October 19 to 22, 1960

Place: Kahului Armory, Kahului, Maui

Theme: The Nurse Looks for Security in Her Community

Principal Speaker: Miss Jo Eleanor Elliott, R.N., Nurse Consultant, WICHE

Other Speakers: Maui community leaders who will participate in a panel on "Security and the Nurse."

Special Events: Wednesday, Board Meeting; Thursday, Night in Old Hawaii; Friday, Banquet; and Saturday, tours around Maui.

Hostesses: Maui District Nurses

President's Message

We hope that our members will make every effort to attend our State Nurses' Convention on Maui. The program should be enlivened by Jo Eleanor Elliott of WICHE. It has been your president's privilege to participate with Miss Elliott in the ANA Board of Directors Meeting. It will be heartening to see the leadership, enthusiasm, and a searching approach to ANA activities in our youthful guest at the convention. Miss Elliott should set our own nurses in Hawaii afire with her directness and perceptive analysis of current nursing affairs.



SISTER MAUREEN
President

The Convention will give impetus to our state campaign for funds for the American Nurses' Foundation. Under the able direction of Alison MacBride, Hawaii's participation in this campaign has been commended at National Headquarters in New York City. We remind you and exhort each member to "Give or Get" contributions to help us meet our quota.

Your president pays tribute to the excellent organization and eager promotion of the Economic Security Workshop held on Oahu. Mrs. Kazue MacLaren and her Committee did a great service to every member by planning and coordinating the stimulating program. Miss Dolores Le Hoty, of ANA Economic Security Unit at New York Headquarters, enhanced the program by her expert collaboration.

This is the last message to you from your outgoing president. I am deeply grateful for the privilege of serving the members of Hawaii Nurses' Association. Your continued support of our efforts to intensify professional pride, to promote membership, and to develop leadership among our colleagues makes us optimistic for the future. It is my prayer that our annual convention will arouse spirited participation and further development under the direction of your newly elected officers. May Divine Guidance light the way to constant progress for our professional organization.

American Nurses Foundation

ANF Fund Drive

The year 1960 marks the fifth year of research in nursing by the American Nurses' Foundation. The Foundation is undertaking, at this time, to further expand this important, necessary research program. As funds become available, the Foundation will make grants to research teams, to colleges and universities, to hospitals, special study groups, and to selected individuals in the promotion of an expanded nursing research program. Research fellowships, research consultant services, and research information services will be initiated to carry the program forward. To implement this, the Foundation, which is the research arm of the American Nurses Association, Incorporated, is conducting a $1,000,000 appeal across the nation. Hawaii's goal toward this fund is $10,000. The state committee is co-chaired by Miss Alison MacBride, Executive Director, Hawaii Board of Nursing, and Dr. Sumner Price, Administrator, Queen's Hospital.

If you have not already contributed to the ANF, please give or get $5.00.

Act immediately. Send your contributions to the ANF, c/o Mabel Smyth Building, 510 South Beretania Street, Honolulu.

ANF, Hawaii Committee

Miss Alison MacBride, Executive Director of the Hawaii Board of Nursing, and Dr. Sumner Price, Administrator of the Queen's Hospital co-chair the Hawaii Committee of the American Nurses' Foundation's Fund Drive. Hawaii's share is $10,000 towards the national goal of $1,000,000, which will be used for the improvement of patient nursing care. Members of the state committee are Mrs. Rosie Chang, Director of Nursing, Hawaii State Hospital; Miss Laura A. Draper; Mrs. Gerry Kurz, Administrator, Kaiser Hospital; Mrs. Alice Scott, Director of Public Health Nursing for the Health Department; Miss Lynne Wigen, Director of Nursing, The Queen's Hospital; and Miss Marion E. King, Assistant Cashier, First National Bank. Also members of the committee are the four district chairmen: Mrs. Irene Kawamura, Oahu; Miss Patricia McGuire, Kauai; Miss Helen Goshi, Maui; and Mrs. Vera Dunbar, Molokai. The island of Hawaii is not participating at this time.

The drive opened with a Kick Off Rally of Oahu nurses on July 21 at the Central Union Church parish annex. Headquarters for the drive are in the Mabel Smyth Building, 510 South Beretania Street.

The fund raising program is related to the structural organization of the American Nurses Association with its subdivisions of state and district groups. National co-chairmen are Mrs. Katherine Densford Dreves, RN, representing the nursing profession, and Mr. Lee H. Bristol, Jr., representing the interests of business and industry and the general public.

Facts About The American Nurses' Foundation

The American Nurses' Foundation, Inc. is a nonprofit organization dedicated to conducting and sponsoring research in nursing.

It was founded by the American Nurses Association in 1955, after five years of intensive study, to meet pressing needs for effective, organized research in nursing and patient care.

The Foundation is guided by a Board of Directors which represent both nursing and the general public.

The goals of the Foundation are to identify nursing needs and enrich nursing knowledge vital to the proper health care of America's rapidly expanding population, and to disseminate information gathered by the Foundation to all members of the nursing profession and to other interested groups.

Since its beginning, the Foundation has directed the expenditure of nearly $300,000 for research. Approximately $100,000 was disbursed in grants to nine institutions mainly universities for carrying out research in nursing studies. Reports on Foundation research programs are available from its library.

Studies supported by the Foundation are in most instances conducted by staffs on which nurses participate with experts in the fields of medicine and health care.

Ways To Strengthen Research In Nursing

The American Nurses' Foundation proposes to achieve its research goals through the following approaches:

1. Identify and sponsor financially the most urgent research projects that can be carried out with qualified personnel of colleges, universities, hospitals, special study groups, and selected individuals.

2. Conduct a limited number of research proj-

ects in special circumstances making use of the Foundation's own staff.

3. Through a fellowship program, stimulate research activities by nurse-researchers, and encourage other nurses with research talents to take part in projects. Matching funds will be made available for research projects undertaken jointly with other organizations.

4. Maintain a staff of skilled and experienced personnel both in the Foundation's headquarters office and in the field to provide counsel and to help plan and develop research projects.

5. Disseminate in the United States and abroad information to interested groups and individuals through such means as monographs, a journal of applied research, field demonstrations, lectures, seminars, workshops, and conferences.

6. Maintain a library devoted exclusively to nursing research needs.

Responsibility For Better Future Health Care

Today research in nursing faces a prime responsibility for finding in a variety of nursing situations new and better methods for patient care, for seeking more efficient ways of using nursing personnel, and for discovering new approaches to the problem of meeting immediate and future shortages of well prepared nurses.



ANF Oohu District co-choirmen conferring with members ot the Kick Off Rally, July 21, Centrol Union Church. Left to right: Elizabeth Maioloha, Mory Lee, Eleanor Apo, co-chairman, Irene Kawamura, co-choirman, Marilyn Virgil, and Harriett Tonaki.

So that research may continue to add to the knowledge which will help nurses fulfill their roles, the American Nurses' Foundation plans to concentrate its efforts in four areas of study:

1. Continue investigations into nursing procedures. Promote or conduct studies, surveys, and demonstrations in patient care for nursing practices. Seek ways to provide greater comfort and safety for patients. Improve human relations with patients and families. Improve methods for health teaching and rehabilitation of patients.

2. Promote research into changing patterns of patient care resulting from the development of new drugs and equipment, new techniques, and new philosophies of health care.

3. Determine the effects on patient care of administrative organization in a variety of units including hospitals, clinics, public health agencies, industries, nursing and convalescent homes, and physicians' offices.

4. Study the nursing needs of different types of patients of varying backgrounds, and nursing needs in different categories of illness. Special emphasis will be directed toward studying chronically ill and long-term patients in their own homes as well as in the hospital.

Research In Nursing Programs

Research programs supported by the Foundation include studies in private duty and industrial nursing, nursing personnel and practice in a metropolitan hospital, nursing service in outpatient departments, nursing for the mentally ill, adjustment of nursing students to psychiatric affiliation, and investigation into practical nursing.

Projects conducted by the Foundation itself include studies in public health nursing, a program for the regular exchange of information with visiting foreign nurses, a program to assist Hungarian refugee nurses to prepare for licensure and practice in the United States, and a five-year study (begun in October, 1959) of family and patient adjustment to the crisis of cardiac disease.



District chairmen meet with State co-chairmen in discussing plons far the American Nurses Foundatian campoign, Hawaii Committee. Left ta right: Helen Goshi, Patricia McGuire, Kouai; Eleanar Apo, Oahu co-choirman; Vera Dunbar, Malokai; and Alisan MocBride, state co-chairman. Stonding: Dr. Sumner Price, state co-choirman.

General Interest

Transfers to Outer Islands

Movement of patients from Hawaii State Hospital to Kauai and Maui has begun. The purpose is to reduce the overcrowded situation at Kaneohe, thereby giving better nursing care to all patients.

The nursing staff from Kula Tuberculosis General Hospital took the lead when ten employees arrived at Hawaii State Hospital May 1, 1960, for a two-week psychiatric nursing orientation program. Participants were registered nurses M. Britten and Duarte; and practical nurses Gladys Naeole, Judy Tadakuma, Stella DeRego, Louise Deponte, Pedro Artates, Pablo Ripani, R. Dancil, and Isaac Cacayorin. On May 16 to 18, Mrs. Elizabeth McCall, Nursing Director of Kula, visited Hawaii State Hospital, along with Mrs. Yamashiro, Operating Room Head Nurse; Mrs. Brown, Dietitian; and Mrs. Hardy, Occupational Therapist.

Nursing staff from Mahelona Hospital on Kauai oriented at Hawaii State Hospital from May 23 to 27. Participants were registered nurses Thelma Hensley, Nursing Director; Jahne Hupy, Day Supervisor; Peggy Nishimitsu, Head Nurse; and Florencia Bromeo, Arlene Shimada, and Bernardino Suetos, licensed practical nurses. From June 6 to 8, Kauai registered nurses Nobuko Hayashi, Mary Paul, and Esther Kono attended the training program. Later in June registered nurses M. Ednaco, B. Awakuni, L. Higashi, and licensed practical nurse T. Villabrille spent a three-day orientation period at Kaneohe.

Included in the orientation program were lectures and films on principles and practices of psychiatric nursing, tranquilizers, and nurse-patient relationship. Case conferences on selected patients were conducted with a psychiatrist and psychiatric social worker. Group sessions were held with a psychologist. Miss Maki Ichiyasu, Group Work Consultant, outlined helpful principles applicable to group activity therapy.

After the actual transfer of patients to the neighbor islands, follow-up was made by Mrs. Alma Takata, Instructor, and Mr. Matson Haae, Psychiatric Aide, from the staff of the Hawaii State Hospital.

The Planning Committee for the Maui-Kauai program included Mrs. Rosie K. Chang, Director of Nursing; Mrs. Colene Wong and Mrs. Katsuko Enoki, Nursing Supervisors; Mrs. Alma Takata and Miss Loretta Schuler, Nursing Instructors; Miss Winifred Ogata, Psychiatric Social Worker; Dr. Geofredo Evora, Chief of Male Service; and Dr. Varady, resident psychiatrist.



Mahelana nurses meet with members af the Hawaii State Hospital staff during arientatian program. Pictured abave are Katsuka Enaki, Sybil Wang, Marjorie Wagner, Belle Braussard, Esther Kana, Mary Paul, and Maki Ichiyasu.

Florence Nightingale Dinner

On May 12, 1960, at 6:00 P.M., a successful cocktail-dinner meeting for members and guests of Oahu District was held at the Princess Kaiulani with "Akuhead Pupule" (Hal Lewis) as Master of Ceremonies.

Mahalo to Miss June Bell and Mrs. Alma Takata, co-chairmen for the event honoring Florence Nightingale! Mrs. Eleanor Fern, in charge of tickets and finance, reports an attendance of 300 people. Mrs. Phyllis Smith was Program Chairman and Mrs. Dorothy Hale, Publicity Chairman. Mayor and Mrs. Neal S. Blaisdell were present.

Special thanks go to the Practical Nurses for their participation in the program.

St. Francis Hospital Supper Meeting

Dr. Paul Tamura, Pathologist at the Queen's Hospital, was guest speaker at the June meeting of the Oahu District Nurses. His topic was on the "Artificial Kidney."

Mental Health Workshop

Preliminary plans for a mental health workshop to be scheduled late in 1960 are being made by a committee headed by Mrs. Yukie Gross, Mental

Health Coordinator at the University of Hawaii College of Nursing. The committee is considering workshop topics, "cose" situations, group leaders, recorders, and resource people.

Nursing Care—1970

A conference for nurse educators and administrators will be held Saturday, October 15, 1960, in the Mabel Smyth Building. It is sponsored by the Hawaii Board of Nursing and the Hawaii Nurses Association.

Among the topics to be discussed at the one-day conference are the trends and viewpoints of the WICHE Report, "Nurses for the West" and the implications for Hawaii in 1970.

Miss Jo Eleanor Elliott, R.N., WICHE Nurse Consultant, who planned and executed the survey of nursing needs and resources in the West, will be in Honolulu to participate in this conference.

Community leaders representing business, education, legislators, and consumers will be on a panel program.

Nursing Education and Nursing Service

*The Present Nursing Situation**

In recent years demands for nursing service have increased beyond those resulting from the population increase. More people are using hospitals, and they are using them more often. The population is aging, and the older age groups, particularly those over 65, require more hospital care. More emphasis is being given to preventive medicine, public health, and industrial medicine.

Based on what is considered good nursing practice today, and on today's demand for nursing services, the N.L.N. has set 300 nurses per 100,000 population as a recommended minimum for nursing service. It considers the ratio of 350 nurses per 100,000 population more adequate for today's nursing needs. The West's 1957 nurse ratio was 275 nurses per 100,000 population, compared with its 1950 ratio of 318. Hawaii's present ratio is 270 per 100,000 population.

The West educates a smaller proportion of its nurses than any other region in the country. In past years, it has depended heavily on migration of nurses from other areas.

The present number of graduates from western nursing schools is not enough to replace normal labor market turnover. The graduates will provide less than half the number of nurses needed by 1970 to maintain the present nurse-population ratio. Graduates from basic nursing programs are 30 per cent below the 1946 level.

TABLE I

Nursing Needs in Hawaii for 1970

1960 population	620,000
Estimated 1970 population	852,300
Estimated increase	232,300
Number of nurses in 1958	1,681
1960 ration of nurses per 100,000 population	271

* Abstracted from Nurses For The West, WICHE, 1959.

Additional Nurses Needed

TYPE OF PROGRAM	TOTAL NEEDED BY 1970			AVERAGE NUMBER NEEDED ANNUALLY		
	At present nurse-population ratio	At ratio of 300 nurses per 100,000 pop.	At ratio of 350 nurses per 100,000 pop.	At present nurse-population ratio	At ratio of 200 nurses per 100,000 pop.	At ratio of 350 nurses per 100,000 pop.
Jr. College & diploma	1,662	1,272	1,484	166	127	148
B.S.	591	625	729	59	62	73
Master's	238	412	481	24	41	48

There is a large gap between educational preparation of a large number of our nurses and the preparation recommended by the profession as indicated in the above table.

Based on present nurse-population ratio for Hawaii each year we need 166 more diploma or junior college graduates, 59 baccalaureate graduates, and 24 master's graduates.

Informed estimates indicate that it would be possible and desirable to expand existing junior colleges and baccalaureate programs substantially if additional facilities and staff are made available. In most cases, existing baccalaureate programs could be doubled; a reasonable expansion goal for junior colleges would be an average graduating class of 50.

We will still fall far short of meeting the demand for nurses. Additional junior college and baccalaureate programs are urgently needed. At the graduate level the existing eight schools with master's programs in nursing cannot possibly expand sufficiently to provide the needed graduate education. Four striking points are:

1. There is a mandate to existing schools to consider plans for major expansion.
2. Western colleges and universities without nursing programs should appraise their potential for moving into this scarcity area. The great strength of the public colleges and universities is in their willingness to respond quickly and imaginatively to needs.
3. The magnitude of the task ahead imposes a special responsibility on schools with graduate programs and schools contemplating starting such programs. Progress

lepends on breaking the bottleneck of the nurse-teacher hortage.

4. Public officials responsible for budgeting for public higher education should take stock of nursing needs nd educational resources in the state. They should decide on the relative priority that should be given to ursing, the kind of nursing care the state wants for the ext decade.

A Federal grant of $150,000 has been awarded o the Western Interstate Commission for Higher Education by the U. S. Public Health Service, Washington, D. C., to strengthen nursing programs on a regional basis throughout the 13 Western states.

The grant will finance the first year of a four-year program to improve the skills of some 800 western nurses in administration, supervision, and teaching. The collegiate nursing schools of the West planned this program through the WICHE Nursing Council, apportioned responsibility for specific sub-regions to each school ready to participate, and submitted a grant request on a regionally-planned basis through the Commission.

According to Jo Eleanor Elliott, coordinator of the WICHE nursing education program, "This unique venture in regional cooperation has several advantages—the interstate sharing of resources, careful planning on a regional basis, adequate geographic coverage, and the prudent use of scarce faculty resources and federal funds."

The eight participating schools of nursing are sending faculty members to participate in a brief, intensive leadership training course organized by the University of California at Los Angeles. Mrs. Alice Kim Mau, instructor, NHSN, is Hawaii's participant. Graduates of this special training program will conduct the short-term courses which will be organized over the next four years in western schools of nursing.

Social Changes Affecting Health Care*

I wish to propose four assumptions to be used as a "platform" for further discussion of the problems of social changes affecting health care. It is for those more closely affiliated with the medical and nursing professions to consider whether these assumptions have validity under the present conditions of, and provisions for, patient care.

I. Sociological assumptions concerning modern medicine:

A. Modern scientific medicine, with its storehouse of knowledge and skills is already able to make new and outstanding contributions to the contemporary problems of both physical and mental health. There appear to be amazing therapeutic potentials available or in the offing for the future.

B. Modern scientific medicine confronts substantial resistance to full and forthright practice of its therapeutic potentials. Resistance ranges from apathy to opposition; some of it overt, some hidden, sometimes conscious and sometimes unconscious on the part of recipients of the service. The medical practitioner is rarely permitted by society to utilize his knowledge and skills maximally. The obstacles to the application of medical care can be almost as great as are those to discovery of the effective therapies. In short, the task for health care is only half accomplished by discovery of new medical skills; the practitioner can still encounter sick and dying people around him, know what to do, and be helpless to do it. This statement, is made, as an assumption; is it also a fact?

C. Here follows what may be regarded as a philosophical or a moral assumption, related to the professional code. There is an implied responsibility or challenge to the physican to fulfill his therapeutic function for the people whom he elects to serve in spite of their apathy or opposition, or at least to some substantial degree in the face of these difficulties. A cardinal criterion of a good professional is that he should know better than do his patrons what is indicated in the needed service to them and he is committed to work positively toward such ends. This involves obligations to a superior level of operation than is customarily associated with such terms as salesmanship or propaganda. A professional worker endeavors, even against opposition, to provide for his clients what he recognizes to be their needs from his specialty even though they cannot possibly understand the necessity for such services.

D. There exists a potential knowledge or know-how in the *application* of medicine that is subject to systemactic study. Such knowledge can be acquired from medical successes as well as from medical failures in gaining acceptance for the services. This field of study is especially relevant to the interests and skills of the behavioral or social sciences.

I merely propose these four statements as assumptions, providing a "platform" for further discussion of the problems selected for our conference deliberations. It is for those more closely affiliated with the medical profession to consider whether they have validity in the present state of medical developments.

II. Emerging goals in modern medicine:

The second topic with which I am concerned is the emerging goals in modern medicine. It behooves me as an interested layman and potential patient to raise some questions here for clarification. As I understand it, the primary purpose of the health professions is the control of disease and promotion of health. This is voiced by the leaderships in the various medical, nursing, and other health specialties. The central aim, as frequently expressed, is continuous improvement of medical care or patient welfare. It is difficult, however, to define either health or patient welfare. Definitions of both are frequently given more in negative than in positive terms. Health, for example, is defined as absence of disease or disability; patient

* Presented at the 1960 Convention, ANA, Miami Beach, Florida, by Leo W. Simmons, Ph.D., Executive Officer, Institute of Research and Service in Nursing Education, Teachers College, Columbia University.

welfare as relief from suffering or discomfort. There appear to be trends toward more positive definitions. The World Health Organization provides one notable example: Health is "a state of complete physical, mental, and social well-being and not merely an absence of disease or infirmity."

Or let us try again for a positive definition of health in a more down-to-earth manner. According to Roger I. Lee, M.D., and Lewis W. Jones in *Readings in Medical Care*, edited by the Committee on Medical Care Teaching of the Association of Teachers of Preventive Medicine (1958), the objectives of good medical care are defined in positive and specific terms. Let me run down the points they make in more specifically defining the issues. According to them, good medical care:

A. Limits itself to rational medicine based on the medical sciences;
B. Emphasizes prevention;
C. Requires intelligent cooperation between the lay public and the practitioners;
D. Treats the individual as a whole;
E. Maintains a close and continuous personal relation between physician and patient;
F. Utilizes and collaborates with social welfare workers;
G. Coordinates all types of medical services; and
H. Implies application of all the necessary services of modern scientific medicine to the needs of all the people.

If this is the promise of medicine for the near future, then it is not difficult for a patient to recognize a great lag between what he appears to be getting and these great objectives. It is a splendid goal calling for positive and improved medical relationships all along the line.

Something of a forecast may be in order here. What the future system of institutional medical care in America will be is hard to predict. But as far back as 1926, changes of great import appeared evident to some in positions of leadership. This is illustrated by the remarks of George E. Vincent, then president of the Rockefeller Foundation: "It looks as if society means to insist upon a more effective organization of medical service for all groups of people, upon distribution of costs of services over large numbers of families and individuals, and upon making prevention of disease a controlling purpose. Just how these ends will be gained only a very wise or a very foolish man would venture to predict. One thing seems fairly certain: in the end society will have its way."

In 1950, Willard C. Rappelye, then dean of the Faculty of Medicine and vice president in charge of Medical Affairs at Columbia University, wrote: "Medical security in this country is coming and it is up to our profession to formulate ways and means by which sound, progressive plans can be drafted. It would be short-sighted and, in the long run, futile to ignore the broad implications of medicine, which must be recognized as much a social as a biological science." He stated further, that, "Anyone who today disregards the relationship of medicine to current social, economic, and political conditions must be literally unwilling to face the fact." That was a decade ago. It is even more obvious today.

The keynote of these forecasts, which now approach realities, is the necessity and expediency of intelligent adaptations by the medical profession to changes that are occurring in the social order and that seriously affect the future of medical practice.

What are the changes in the social order that so critically affect interpersonal and interprofessional relationships in medical practice? There are some very broad changes that are shaking the old foundations. There are others within the medical institutions themselves that are upsetting the old order of staff-patient relations. Let us divide these two sets of forces into the broad *outside* changes and the more specific *inside* ones.

III. Broad outside changes:

A. Of the broad changes, there are first the increasing mobility of the population. We are moving about over the earth at a rate and pace that man has not before known; shifting our homesites repeatedly in the course of a lifetime. Such constant movement complicates the issue of continuity in medical care and the interpersonal relationships involved.

On top of the horizontal movement is our status seeking or social mobility, moving up the status ladder hopefully at least a rung per generation anyway. With shifts in social status follow shifts in standards and norms of consumption; then we want better homes, better clothes, better medical care, etc.

In a sense we have become *doubly nomadic*, on horizontal and vertical planes. Such population mobility is bound to upset established norms and expectations in medical practice.

B. In the second place the public of potential patients is becoming more *sophisticated*. There was a time when the physician knew more about almost anything than did anybody else within easy reach. Medical personnel enjoyed a kind of intellectual aristocracy. This isn't true any longer. Now almost any physician, even in the semi-civilized spots in America, face people who know or think they know, more about many things than their doctor can possibly know.

A physician was heard to say recently that it was "disturbing" what some of his patients know, *even* about medical matters! He is a general practitioner and went on to say that individuals attempt to diagnose their own illnesses, by-passing him, and going directly to a specialist.

Later a specialist commented that patients come to him now even *prescribing* for themselves—"Doctor, a little penicillin, please."

These are extremes, to be sure, but the fact stands that people who are served medically today are more and more sophisticated and critical about the medical services they receive than were their grandparents.

C. A third broad change affecting medical service i

hat has been called the "commercialization of the pro-
ssions." Once there were people, known as profes-
onals, whose services seemed "beyond price" in a
nse. There were physicians, clergy, professors who
ursued careers almost irrespective of their incomes and
stayed at their stands" when offered several times
ieir earnings to go elsewhere.

But change has been taking place. These dedicated
rofessionals have become substantially commercialized.
Ve think now of a professor less as an academic "long
air" and more as a "sharp" business man. We are
lso beginning to see physicians without their halos, as
airly typical human beings with skills to sell—at a
rice. Recently two disturbing books were published:
he Academic Market Place that describes how young
rofessors get their positions and promotions and *The*
)octor's Business which follows the same market-place
pproach. Who or what can stem the tide of com-
iercialism sweeping over us?

D. A fourth change of major significance is the shift
i age composition and disease prevalence in our pop-
lation. The communicable diseases are on their way
ut and the chronic, long-term illnesses are gaining
ocus in medical and hospital practice.

In coping with the communicable diseases the health
rofessions did things mostly *to* or *for* patients. With
ie chronic diseases they have to depend much more
pon the patient *cooperating* in the therapeutic pro-
rams. This in itself calls for many modifications in the
ld norms of staff-patient relations.

E. In the fifth place, there is a transition on our part
rom a religio-philosophical orientation toward a mate-
ialistic and scientific attitude to life and its problems.
Ve all get over-sold on the idea that science can do for
se almost anything—and then find ourselves distraught
y the fact of its limitations. Where science leaves off,
s approach provides little help and cold comfort.

F. A sixth broad "outside" change has been the
rowth and spread of organized interest groups. We
ave become a highly organized people—organized
ibor, organized professionals, organized producers, and
rganized consumers as well as organized salesman. It
ppears as though we must organize or perish. The
nion card of an organized group, with its bargaining
nd pressure apparatus, seems all but a necessity now
i getting whatever we consider to be our rights, our
ues, or our needs.

This development has entered the health field and
s altering old norms and patterns in medical care. Wit-
ess, for example, governments, unions, and other or-
anized interests engaged in bargaining for medical
ervices or building their own hospitals, hiring their own
nedical personnel, and shaping up their own system of
nedical care.

But enough for *outside* changes. Let us look around
nside the medical institutions and spot some of these
najor changes.

V. Changes within medical institutions:

A. First observe the vast expansion of medical equip-
nent or armamentarium as it is sometimes called. Com-
)are, in short, the equipment that doctors may com-
nand today with the "little black bag" that was their
tock-in-trade for diagnosis and treatment in the yester-
ears. We know that in capital outlay for plant and
quipment alone, medical practice has become a giant
nterprise—a far cry from the horse-and-buggy projects.

Needless to say, the skills, functions, and relation-
hips of the health professionals have had to keep pace
vith the expanding equipment and techniques. Person-
nel become attendants to gadgets and documents as much or more than to patients directly, and, in the eyes of the patient, doctors and nurses resort more and more to forms of remote control in their ministrations.

B. A second change is in the elaborations of institutionalized medical care. To significant degrees the doctor and the nurse, and others also along with the patient, become something like cog-units in an ever-more tightly-structured system. Their behavior (including perhaps the way they think and feel) become patterned and interlinked, chain-like, into procedure-processes somewhat similar to "production line" developments in industry. The freedom of the physician is thereby restricted: the ingenuity and spontaneity of the nurse is limited; the patients feel that their uniquely personal characteristics are slurred over, neglected or squelched.

It is now common to speak of the "structure and culture" of a hospital as a distinct and different phenomenon in important respects from the social structure and culture of the community that surrounds it. Part of the tasks of social scientists is to study the institutionalized medical system as such in order to discover when and where interpersonal conflicts and stresses between staff personnel and patients are primarily the consequence of the system rather than individual idiosyncracies.

C. A third change in medical institutions has been the rapid increase in the use of medical and para-medical specialties in varied types of patient services. We are still in the throes of readapting medical care in terms of an increasing host of specialists gathered around the patient, and to whom he is expected, as a model patient, to adapt, chamelion-like, to each in turn.

To add to the patient's confusion, these varied "specialists" are, not infrequently, very sharply dividing up areas of their responsibility, contending or competing for positions, prerogatives, or for pay, that correspond to their conceptions of their particular competences.

If the patient can gain sufficient composure to observe carefully what is going on around him, he will recognize two kinds of specialists coming and going. There are the scientific specialists that have learned more and more about less and less in the field of disease and patient problems. They are the experts, and are of course indispensable and expensive.

Then there are the factory-shaped specialists that have been quickly taught just a little about a small task in order to do it passably well and cheaply. They were once called attendants and were dispensable and replaceable. They are now moving up with more dignified titles and labels and more prerogatives and pay.

The limitations and complications of spawning specialization and fragmentation of services around the patient are products of our times and constitute, as yet, unsolved issues in interpersonal relations.

D. A natural component of specialization is interdependency of personnel that results in a sharp splitting up of individual responsibility and a pinning down of blame on those who fail in the linked segments of responsibility. This used to appear quite puzzling in the hospital—how quickly the finger of blame points, and perhaps how unerringly. One could wonder if evil motives were attributed more readily in hospitals than elsewhere or if personnel mistrusted each other more there than is usual elsewhere. Then it might dawn upon one that the practice of blaming of personnel is a built-in part of the system, with checks and counter-checks, and maintained largely by the system. It may help to insure discipline, but the accustomed pattern does not much help in the enlightening of the understanding of individ-

ual behavior. Blame in the hospital deserves considerable systematic study.

E. A fifth important change within medical practice has been the broadening perspective on medical care, or what is considered to constitute good patient care.

The old perspective was focused on the treatment of acute illness and, as a matter of fact, the modern hospital arose to provide treatment for such emergency ailments, for the mentally ill, and for indigent persons. Our new horizon on patient care has extended itself greatly from that.

What we have done is to expand the concept of patient care to preventive measures on the one hand and rehabilitative provisions on the other. More than that, we are making room in the new concept of comprehensive patient care to include all the services that the varied specialists can contribute to the well-being of the patient. This expansion in our ideas of improved patient care overrides the traditional views. To try to fit these contemporary concepts into the old patient-care pattern resembles, figuratively, the attempt to fill old wineskins with the new wine.

F. A sixth change, and the last that we shall list, within the confines of medical practice, has been the rapid growth of pre-payment plans, the rise of group medical practice, and the greater involvement of the government in medical provisions. These three more-or-less simultaneous developments carry in themselves potentials for profound modifications in professional patient relations.

Take the pre-payment plans. Heretofore most of us, when we have gone into the hospital as patients under the old system of payments, have been subjected to the full authority of the staff. When an issue has arisen and becomes sharply drawn between the patient and the hospital authorities of various ranks it has, not infrequently, boiled down to this. Hospital or medical authority has said to the patient, "If you don't like it here, you can go elsewhere." If he does it, "discharged against advice" may then be written into the record.

Now that is quite in order if the patient is a "charity case," or if he is a private patient paying his way on the spot; but it carries a sour, unfair, and nearly intolerable connotation when the patient has been paying for his service for 10, 15 or 20 years—and has now come to get his pre-paid medical care. It is just out of order to make such a proposition to him. He has a stake in the firm. Moreover, the cost of medical service has become so magnified that to pay once is all that most of us can muster. We can't go elsewhere on a whim. Indeed, the price of available patient care has become so great that it is now more urgent to insure against sickness and its costs than to insure against death. Sickness may disrupt the financial status of the family more than death does.

Let us consider for a moment the spread of group medical practice of the various forms. It is still "on its way." Such developments that tend to combine "packaged bargains" in medical care with extensions in medical services, and by teams of cooperating specialists, carry potentials for further modifications in patient-personnel relations.

Then through the instrumentality of the Federal Government, also, increasing amounts of medical care for growing segments of the population are being covered and measurably controlled on a national or state basis. Certain estimates of present medcial care under government sponsorship in the United States, even, have already moved about halfway toward some of group responsibility for the health service of the population.

In summary, we have saluted the medical profession for what it is now able to do for the health and welfare of all of us as potential patients. We are somewhat cognizant of a great lag between what is *actually done* for patients and what *could be done* by use of the full medical potentials. We as the public are dissatisfied with present medical and hospital practice and there are mounting pressures for improvements. The improvements may come by means of the better application of existing medical knowledge and skills. Here we know that the medical profession will meet with substantial opposition on the part of some potential patients. The "lag" between what we *get* and what we *may have* in medical care will be slowly overcome, however, and we make bold to assume that systematic study and research on the social phenomena of medical practice will speed the orderly progress of staff-patient relationships.

We have cited six broad changes in the social order that have at least an indirect bearing on staff-patient relationships: population mobility, general sophistication, commercialization of the professions, shifts in age composition and disease prevalence in the populace, changes from a religious philosophical to a scientific orientation, and the growth and spread of organized pressure groups.

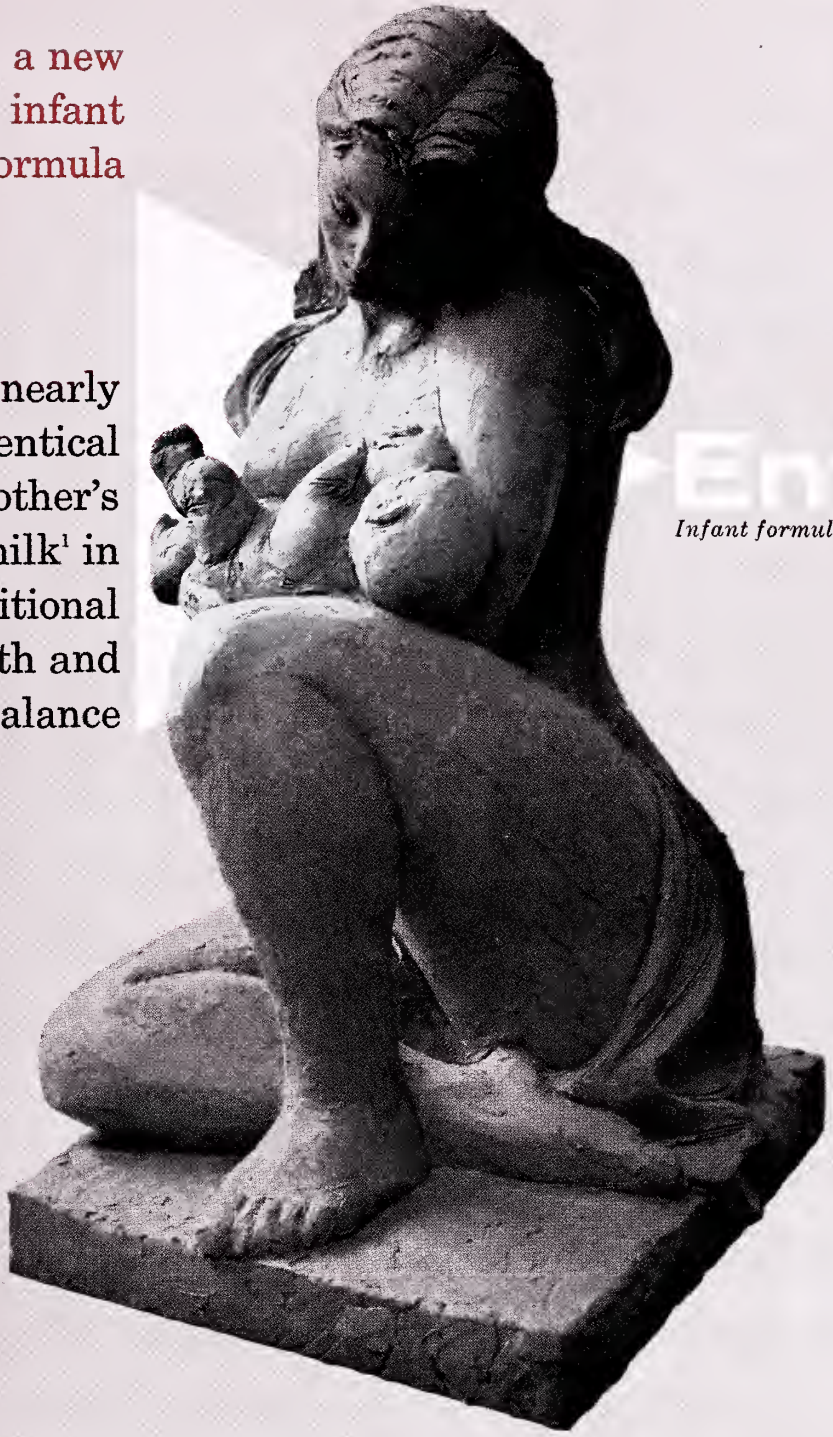
We have also identified six more specific changes within medical practice: expansion of equipment and capital investment, growth of institutionalization, increase of specialization (of both brands), the sharpening of blame potentials, expansions in the concepts of patient care, and the rapid growth of pre-payment plans, group medical practice, and the greater participation of the government in the provision of medical care.

Amid such a flux of trends outside and inside the medical institutions, is it any wonder that personnel-patient relations should be somewhat unsettled or that the health professions, caught within the cross-currents, should be concerned about what steps to take and in what order?

In conclusion, one thing seems fairly certain. There exist no easy panaceas and simple gadgets that can insure full harmony of personnel and steady progress in health care. Two cautions should be clear to us. First, the solutions of our yesteryears are insufficient to cope with our changing times. Second, the "magic" of our public-relations gimmicks is too superficial to resolve the deeper issues. It is recommended that our medical leadership examine systematically and with professional aid the ways and means by which medical practice fails to keep pace with changes in the social order and to consider the potentials of social research and planned experimentation for overcoming the prevailing "lags."

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1. Macy, I. G.; Kelly, H. J., and Sloan, R. E.: With the Consultation of the Committee on Maternal and Child Feeding of the Food and Nutrition Board, National Research Council: The Composition of Milks, Publication 254, National Academy of Sciences and National Research Council, Revised 1953. 2. Brown, G. W.; Tuholski, J. M.; Sauer, L. W.; Minsk, L. D., and Rosenstern, I.: Evaluation of Prepared Milks in Infant Nutrition; Use of the Latin Square Technique, J. Pediat. 56:391 (Mar.) 1960.

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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

CAROLYN E. MCCUE, *Editor* BERYL UYEHARA, *Associate Edito*

Reports

MEMBERSHIP COMMITTEE REPORT 1959-1960

Active members	
Old	56
New	8
Associate members	
Old	7
New	0
Students	10
Total	81

SCHOLARSHIP COMMITTEE REPORT

For the first time this year we were able to give an award to an outstanding senior in the University of Hawaii Medical Technology course. Judging of eligible students was based on scholastic qualifications and practical ability displayed during internship at the training hospital. The recipient was Jane Okada.

FINANCE REPORT

Finance Chairman Jack Furuta stated that the first-aid kit sale grossed $2,785.70 and netted $930.00. The prize, a trip to Maui or Kauai, went to Betty Hughes for making the most sales.

REPORT ON SALARY INVESTIGATION

Betty Hughes stated that it had been suggested that the rapid turnover in laboratory personnel might be due to the wide discrepancy between salaries in Hawaii and those in other areas. The full range is lower than that in other states. She said that the committee was formed with the following objectives:

1. To study the salary range in and around the Honolulu area.
2. To compare medical laboratory technicians' salaries with other jobs in this same area.
3. To compare medical laboratory technicians salaries with those of other states, concentrating on California where so many of our Island-trained technicians go to seek employment.
4. To suggest a salary scale if the study indicated that such is needed.

After much discussion the members decided on the following salary range:

Chief Technician—$500-$620 (depending on duties).
Head Technician of Department—$450-$570.
Medical Technician—$400-$520.
ASCP—Eligible—$390 starting (to be left at discre tion of the pathologist.
Applicant with Master's Degree—To be left at discre tion of the pathologist).

It was moved and seconded that the Societ send the revised copy to all the pathologists askin for their recommendations and opinions.

POST-CONVENTION NOTES

Plan now to attend the post-convention spon sored by the American Society of Medical Tech nologists. The convention will be held in Hono lulu, June 18 to 22, 1961. Please help our loca convention committee which is working hard t present an interesting program.

President's Message

The 28th annual American Society of Medica Technologists Convention was held at the Ambas sador Hotel in Atlantic City, New Jersey, in June I attended the afternoon session of the pre-con vention Advisory Council meeting held on Jun 19. The Council, which is composed of the presi dent and president-elect of each state society, re viewed all committee reports of the past year and voted on recommendations wherever they were made in the reports. The Council's decisions on these recommendations were then presented t the House of Delegates later in the week.

The opening ceremonies on the morning of June 20 were attended by approximately 700 people. ASMT president, Ruth Heinemann, pre sided and following the invocation there was the presentation of the colors, pledge to the flag, and greetings from representatives of the host state societies and the local medical profession. It was interesting to note that the invocation at the open ing ceremony was given by a protestant minister, at the Awards Banquet by a Catholic priest, and at the House of Delegates by a rabbi.

In between attending scientific sessions, I spent the time at the Northwest Orient Airlines booth helping their representative to hand out travel brochure kits, our lava souvenirs, and Hawaii Vis itors Bureau matchbooks. By the third day of the convention, 1,500 brochure kits and 700 packets of the lava souvenirs had been distributed. The NWA booth was ideally situated on the way to the meeting rooms. Everyone attending or leaving

he scientific sessions had to pass it. This was the easiest way to meet people and tell them about the Post-convention to be held in Hawaii next year. The questions asked ranged from the cost of the trip, the origin of lava, the scientific program to be presented, and entertainment to be offered to the availabiltiy of baby sitters and to job opportunities. The ASMT members definitely did not want to come to Hawaii to hear mainland speakers. We must offer our local medical men and subject matter pertaining to the Hawaiian Islands. Among those who stopped at the NWA booth was Captain Ruth Cross Shatterly of the United States Air Force, a former HSMT member and one of the first Hawaiian delegates to a national ASMT convention. Quite a few male technologists were evident in the crowds of people passing by and it turned out that many were presidents of their state societies. Total registration, including members, technical visitors, visitors, and exhibitors was 1,618.

I met the Washington State delegates who were very helpful in acquainting me with convention machinery and also were eager to know what Hawaii was planning for the Post-convention. One of these delegates introduced me to President Ruth Heinemann, who arranged to have me address the House of Delegates. I was invited to sit in on a meeting with the Seattle Convention Chairman, Lucille Larson; ASMT Executive Secretary, Rose Matthaei; and Lenna Loyd of the Oregon Society. They discussed the program for the 1961 convention in detail. I gathered much information on how to set up a convention. All meetings or business sessions, official dinners, and other exhibits should be held at the same place. It is better to ask local medical and professional men to speak because availability is assured and travel and hotel expenses are reduced. All commitments should be in writing. Final contracts and programs should be ready between January 15 and February 1, 1961, at the latest.

On the afternoon of June 23, the first session of the House of Delegates was called to order with 301 delegates seated. I was very much impressed with the way it was organized. It resembled a pint-sized political convention complete with signs on the tables for each state. The Hawaii and Texas delegations shared the same table. Business consisted of voting on various amendments to the Constitution and Bylaws, voting on recommendations made by committees, and electing new officers. It was all conducted strictly according to parliamentary procedure and Robert's Rules of Order.

The Awards Banquet was a tedious affair, with 1,600 people in attendance and long speeches by a toastmistress and the guest speaker. The only bright note was the music rendered by an instrumental trio. As the roll call of states went on, the trio would play that state's song and the delegates would stand up to be applauded. Aloha Oe was played on Hawaii's call.



Pictured at ASMT Canventian in Atlantic City were (left to right): unidentified ASMT member; NWA representative Adeline Gran; ASMT executive secretary, Rose Matthaei, and HSMT President Larene Leong.

The final session of the House of Delegates began with the re-election of the President-elect, due to a tie, and the Board of Registry member at large, because of a three-way split. The election of the Nominations Committee then followed. Next, President Ruth Heinemann called attention to the presence of the Hawaiian delegate. The Legislation Committee brought up the threat of the Association of Medical Technologists who have predicted they will surpass ASMT in five years. They have already made inroads in Oklahoma and many other states. We can combat this by building up our membership and educating doctors and pathologists in the advantages of hiring ASCP registered technologists. The Seattle convention chairman was called upon to make an announcement about their planned program and then she introduced me as "a wahine from Hawaii." The invitation extended to the post-convention was ended with a jingle.

A short post-convention Advisory Council meeting took place with election of officers for that governing group. Late Friday evening, I boarded a chartered bus to Philadelphia to attend the post-convention workshop. The chemistry workshop on the cholesterol determination was certainly enlightening and well planned.

I sincerely believe that I gained much professionally as well as socially. If the enthusiastic response of the ASMT members to the advance post-convention publicity and my personal invitation is any indication, then we can expect a sizable number at this great event. We in Hawaii will have to put on a post-convention worth remembering. Let's all kokua.



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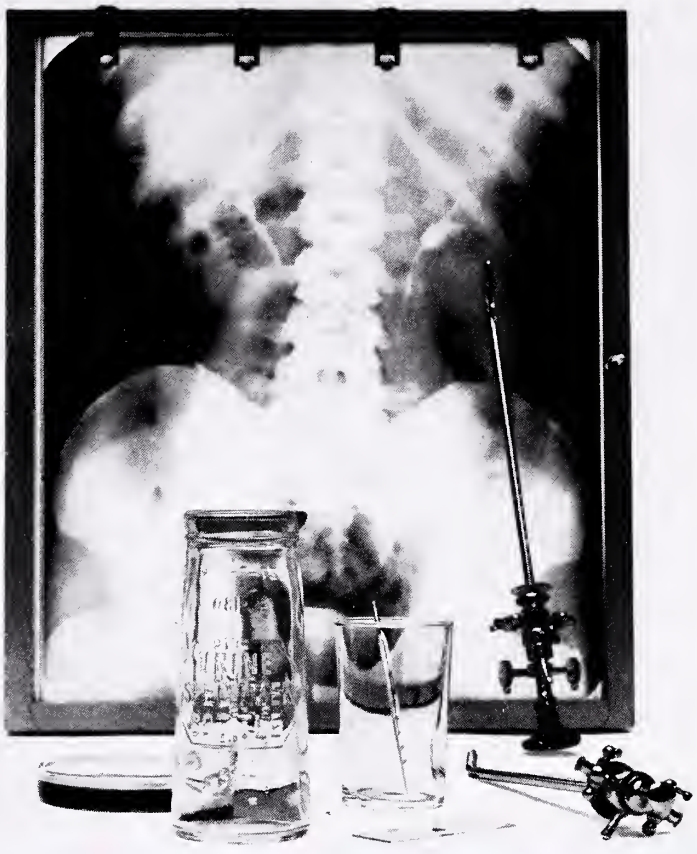
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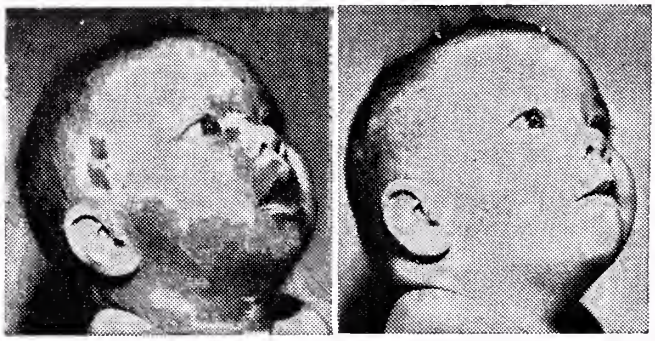
Precautions: Usual sulfonamide precautions apply.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: *Antibiotic Med. & Clin. Ther.* 3:378 (Nov.) 1956. 2. Boger, W. P.: In: *Antibiotics Annual* 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: *Antibiotic Med. & Clin. Ther.* 5:604 (Oct.) 1958. 4. Anderson, P. C., and Wissinger, H. A.: *U. S. Armed Forces M. J.* 10:1051 (Sept.) 1959.

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HAWAII MEDICAL ASSOCIATION

(Continued from page 70)

the administering body for this fund should be discussed after the fund is established. Dr. Fleming felt the assessments should be sent out with the bills for dues. It was noted that it had already been decided to send the assessments out on the state level. It was decided to proceed with this project in accordance with the plan outlined by the Committee.

ACTION:

It was voted to accept the auditor's report.

It was voted to finance one additional doctor's expenses to the White House Conference on Aging if he can go as an official delegate.

PUBLIC RELATIONS COUNSEL

Dr. Cushnie advised that after he had learned that Honolulu County had appointed a committee to look into this matter of employing public relations counsel, he had conferred with Dr. Pang and agreed that it would be unnecessary to pursue it further at the state level. He complimented Dr. Pang and his committee on the excellent report which had been presented earlier to the Board of Governors' meeting, and thanked him for his cooperation. The Board of Governors of the HCMS voted to accept the committee's report to execute a contract with Mr. Hugh Lytle to make an exhaustive 30-day study of the public relations needs of the medical profession and to present suggestions for a long-range program. The Board of Governors recommended

(Continued on page 90)



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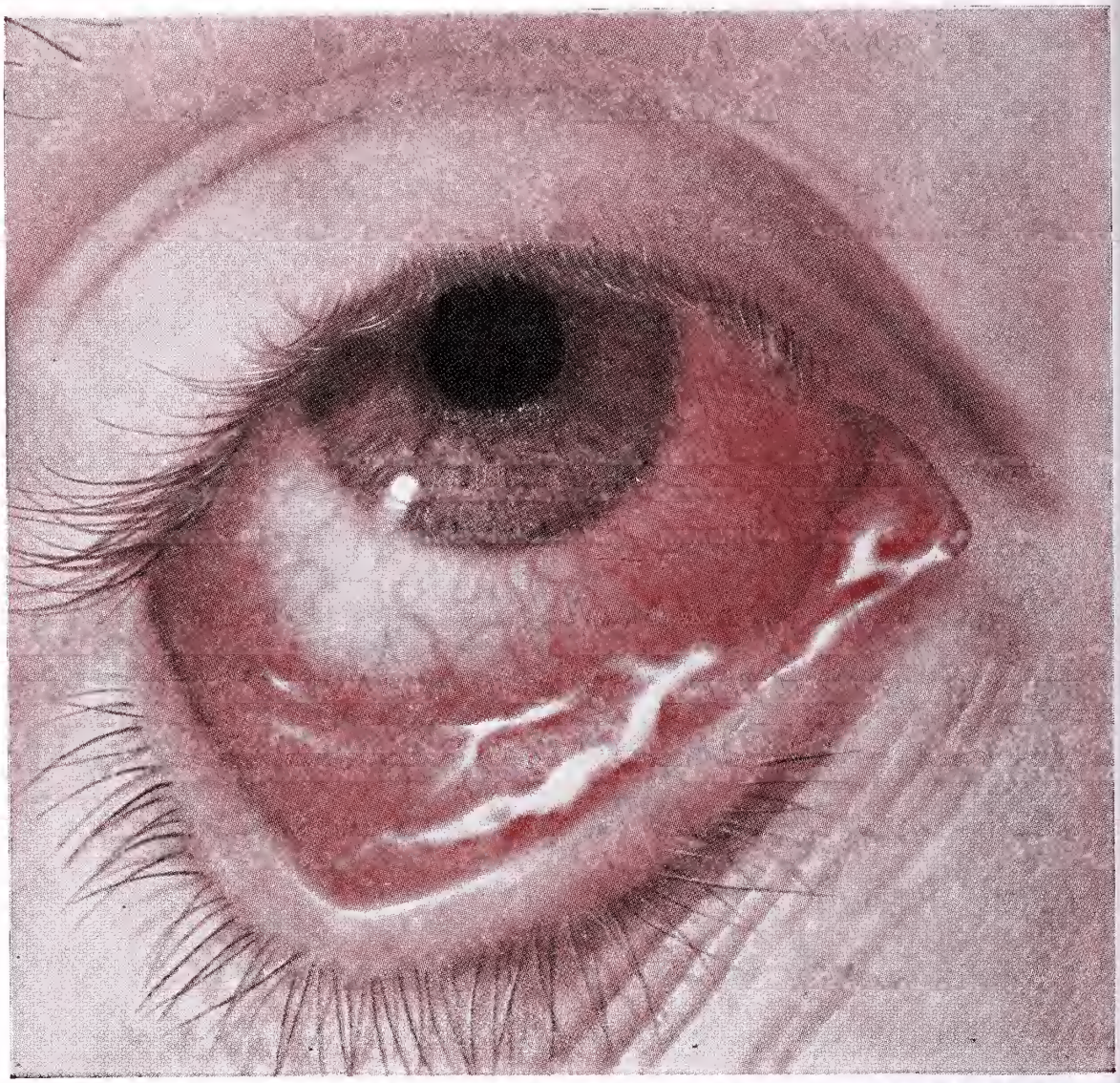
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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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HAWAII MEDICAL ASSOCIATION

(Continued from page 86)

that this be carried out at the state level. A lengthy discussion followed on the problem of financing the study which would cost $1,000. It was noted that the County has money available through its Bureau of Medical Economics but that there might be a problem there because of the tax situation.

ACTION:

It was voted to recommend to the Bureau of Medical Economics that they employ Mr. Hugh Lytle to make a study and recommendations for a public relations program for the Hawaii Medical Association for one month at a total cost of $1,000.

It was voted that in the event the Bureau of Medical Economics is unable to make this expenditure that the Hawaii Medical Association would pay for it.

HMSA COVERAGE FOR ASSOCIATION EMPOYEES

A new employee of the Association desirous of continuing HMSA coverage under the Group IV plan will be covered on a contingency basis through the Bureau of Medical Economics policy. This matter was discussed with the HCMS treasurer who agreed to this procedure in view of the precedent already set with the inclusion of an employee of the Mabel Smyth Building. A further discussion on this will take place at the next meeting of the BME's Board of Directors. It was noted that the BME and the HCMS pay for the HMSA coverage of their employees. This policy will be discussed at the first meeting of the ad hoc committee appointed to study the salary structure of the Association.

RODNEY T. WEST, M.D., *Secretary*

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References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs an Therapy 5:60 (Feb.) 1960. 2. Friend, D. H.; Clin. Phorm. & Therap. 1:5 (Mar.-Apr.) 1960. 3. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

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COUNTY SOCIETY REPORTS

(Continued from page 68)

thorized and directed on behalf of, and in the name of, this Honolulu County Medical Society, an unincorporated association, to make, execute and deliver any and all documents, deeds and instruments necessary, proper or convenient to effect the foregoing, effective on and as of this 5th day of April, 1960.

ACTION:

It was moved by Dr. Mason, seconded by Dr. Berk, that Resolution #1 be approved. The motion was carried.

Resolution #2

WHEREAS, On March 14, 1960, by Charter of Incorporation duly issued on that date by Charles H. Silva, Treasurer of the State of Hawaii, Honolulu County Medical Society was duly incorporated pursuant to the laws of the State of Hawaii, having as a purpose the acquisition of all of the assets and privileges, subject to all ot the agreements, liabilities, and obligations, of this Honolulu County Medical Society, an unincorporated association; and

WHEREAS, All persons who were members of the Honolulu County Medical Society, an unincorporated association, as of the 14th day of March, 1960, became, pursuant to the provisions of the aforesaid Charter, members of the said corporation in the same status and class of membership as they then had and held in this unincorporated association pursuant to its Constitution and Bylaws; and

WHEREAS, On this 5th day of April, 1960, in accordance with resolution duly adopted in accordance with its Constitution and Bylaws, this unincorporated association transferred to the said nonprofit corporation all of its assets, subject to all of its liabilities, which were assumed by the said nonprofit corporation; now therefore be it

Resolved, that Honolulu County Medical Society, an unincorporated association duly chartered on December 16, 1925, by the Hawaii Medical Association, shall be and said unincorporated association hereby is dissolved.

ACTION:

It was moved by Dr. Mason, seconded by Dr. Berk, that Resolution #2 be approved. The motion was carried.

Following the acceptance of the foregoing resolutions by the membership, Dr. Pang announced that the Honolulu County Medical Society, an unincorporated association, was now dissolved.

Dr. H. Q. Pang, President, then called the first meeting of the Honolulu County Medical Society, Incorporated, to order.

Dr. Mason, Chairman of the Constitution and Bylaws Committee, read the following resolutions:

Resolution #3

Resolved, that the Honolulu County Medical Society, a Hawaii nonprofit corporation, shall and does hereby accept and acknowledge delivery and receipt on this 5th day of April, 1960, from Honolulu County Medical Society, an unincorporated association, all property, rights, franchises, and privileges, tangible and intangible, real, personal, and mixed, of every kind and description, and wheresoever situate, held, possessed, owned, and claimed by said unincorporated

(Continued on page 96)



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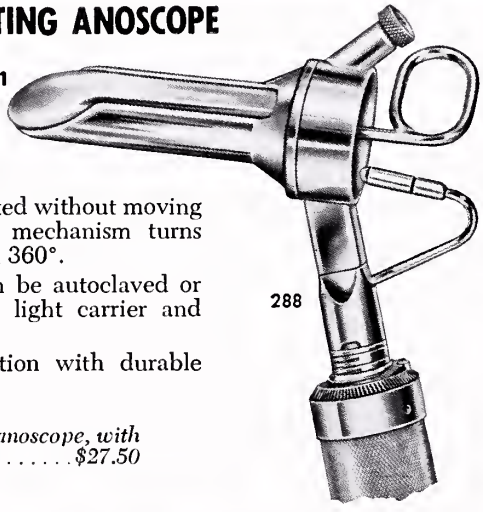
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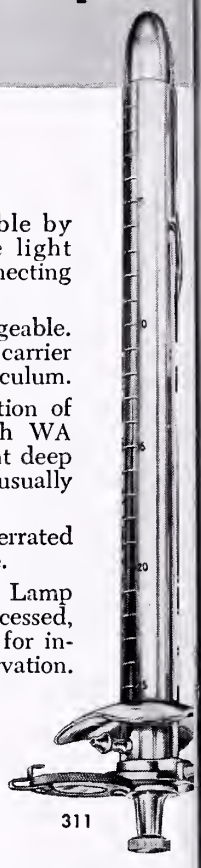
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- All parts are interchangeable. Any obturator or light carrier can be used with any speculum.
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- No specular reflection. Serrated interior eliminates glare.
- Vision is unobstrueted. Lamp and light carrier are recessed, giving maximum space for instrumentation and observation.

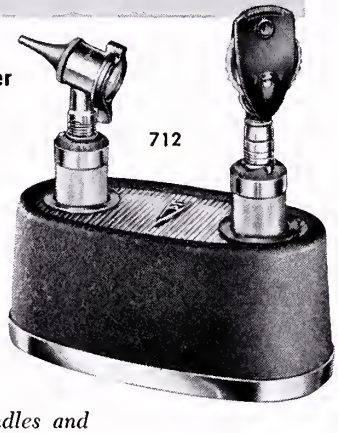
No. 311, sigmoidoscope, 25 cm. length $40.00
No. 312, proctoscope, 15 cm. length $40.00



END BATTERY REPLACEMENTS with Welch Allyn RECHARGEABLES



Rechargeable Battery Handles with Desk or Wall Mounted Charger



- Always fully charged in office use.
- Provide satisfactory illumination longer than standard batteries, without recharging.
- Handles are small and lightweight, fit all WA instruments.
- Charger takes only 7½" x 4" space, plugs into 110 v. AC outlet.

No. 712 Two rechargeable handles and charger (less instrument heads) . . . $60.00

Rechargeable Handle fits all WA medium set cases

• Provides satisfactory illumination longer between charges than standard medium batteries • No separate charger • Cannot corrode • Cannot overcharge • May be recharged thousands of times • Fits all WA instruments.

No. 717, Rechargeable battery handle $20.00
No. 717-B, Extra bottom section $14.50

WA PROFESSIONAL POCKETLIGHTS



Made for medical use with the s quality standards as all WA instrum Gives clear, brilliant spot of light.
No. 777, $



Focusing Pocketlight—like 777 except with conder lens cap to change proje light from pinpoint to beam. *No. 778, $*



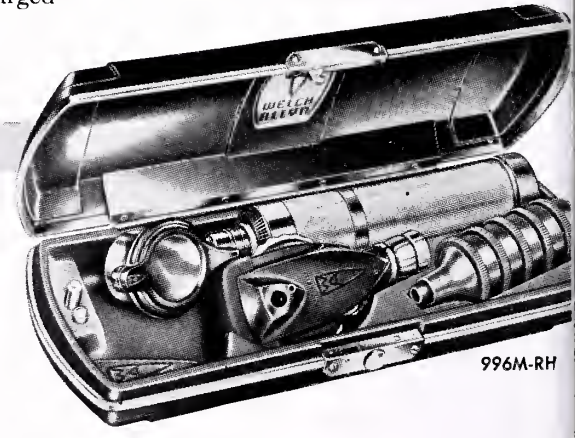
Ocular Pocketlight — like 777 exeept with Finoff- nosepiece. *No. 779, $*

WELCH ALLYN DIAGNOSTIC SETS

Welch Allyn combination otoscope-ophthalmoscope sets are now available with the new rechargeable handles as well as with conventional battery handles.

As always, there is a wide choice of otoscopes and ophthalmoscopes to suit individual preference. Cases can also be chosen to meet the user's needs.

Illustrated is WA set No. 996M-RH. It includes No. 121 ophthalmoscope, No. 201 diagnostic otoscope, new rechargeable handle, in No. 21M deluxe case . . . $87.50. Other combination sets from $67.50 to $90.00.



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TRICOFURON IMPROVED (Suppositories and Powder) cured 143 of 161 patients with vaginitis due to Trichomonas vaginalis, Candida (Monilia) albicans, or both. "Almost immediate symptomatic improvement was noted with the first insufflation."

Criteria for cure: freedom from infecting organisms as well as symptoms on repeated examinations during a three-month follow-up. This cure rate of 88.8% is "surprisingly similar" to results reported by earlier investigators.

Coolidge, C. W.; Glisson, C. S., and Smith, A. S.: J.M.A. Georgia 48:167, 1959.

TRICOFURON®
IMPROVED

2-step treatment brings swift relief, eradicates stubborn trichomonads, Candida (Monilia) albicans, Hemophilus vaginalis

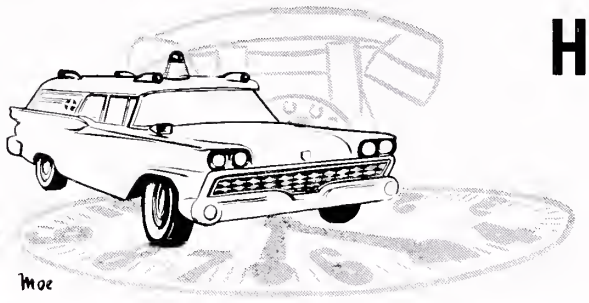
1. POWDER for weekly insufflation in your office. MICOFUR®, brand of nifuroxime, 0.5% and FUROXONE®, brand of furazolidone, 0.1% in an acidic water-dispersible base.

2. SUPPOSITORIES for continued home use —1st week one suppository in the morning and one on retiring. After 1st week, one suppository at night may suffice.

Continue use of suppositories during menses. Treatment should be continued throughout a complete menstrual cycle and for several days thereafter. MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base.

Rx new box of 24 suppositories with applicator for more practical and economical therapy.
Also available:
box of 12 suppositories with applicator.

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Hawaii Ambulance

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24 Hour Service

COUNTY SOCIETY REPORTS

(Continued from page 92)

association, subject, however, to any and all debts, obligations, and liabilities this said Honolulu County Medical Society, a Hawaii nonprofit corporation, shall and hereby does assume and agree to pay and discharge; and be it further

Resolved, that Honolulu County Medical Society, a Hawaii nonprofit corporation, in consideration of the receipt and delivery, as aforesaid, shall and hereby does agree to indemnify and hold and save harmless the Honolulu County Medical Society, an unincorporated association, and all of its officers, Governors and members, from and against any obligation to pay, or liability for payment of, any and all of the debts, obligations and liabilities as aforesaid; and be it further

Resolved, that the President and the Secretary, or the Treasurer, shall be and they hereby are authorized and directed, on behalf of and in the name of Honolulu County Medical Society, a Hawaii nonprofit corporation, to make, execute, and deliver any and all documents, deeds, and instruments necessary, proper or convenient to effect the receipt of the property aforesaid, the assumption of the debts, obligations, and liabilities aforesaid, and the indemnification as aforesaid.

ACTION:

The motion to adopt Resolution #3 made by Dr. Mason was seconded and carried.

Resolution #4

Resolved, that Honolulu County Medical Society, a Hawaii nonprofit corporation, shall and hereby does adopt as the Bylaws of said nonprofit corporation that certain form of Bylaws as presented to a meeting duly called and held for the purpose, inter alia, of adopting such Bylaws as the Bylaws of this corporation; and be it further

Resolved, that the appropriate officers of this corporation be and they hereby are authorized and directed to execute and file with the Treasurer of the State of Hawaii the necessary certificates relating to the adoption of said Bylaws.

ACTION:

The motion to adopt Resolution #4 made by Dr. Mason was seconded and carried.

A letter was read from Hawaii Heart Association, inviting applications for grants in the field of cardiovascular or related research for the 1960-61 program year.

A letter from HSMA was read. It informed us that the HCMS's representatives, Drs. J. Frazer, Herbert Chinn, George H. Mills, and alternate representatives, Drs. L. Fernandez, Y. Fukushima, P. Gebauer, Warren Wong, were elected to the HMSA Board of Directors. Also, that Mr. Richard Kennedy was re-elected to the HMSA Board as lay representative of the HCMS.

Another letter from HMSA reported that their current procedure on processing claim forms for members receiving services from nonparticipating physicians has been amended.

(Continued on page 100)



Dr. Steele Stewart

Rx the doctor prescribes **TRAVEL**

Immunize Against Fatigue

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A Long Trip
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ALGIC™

Antihistaminic/Tranquilizer/Decongestant

- Provides comprehensive control without drowsiness

The anxiety underlying allergic conditions is allayed, and the needed antihistaminic and decongestant actions are provided. Drowsiness is prevented by specific CNS anti-depressant action.

"Algic is highly effective in the symptomatic therapy of perennial allergic coryza. 82% of fifty patients experienced marked therapeutic effect. Side effects were few and only one patient required withdrawal of the drug because of sleepiness."

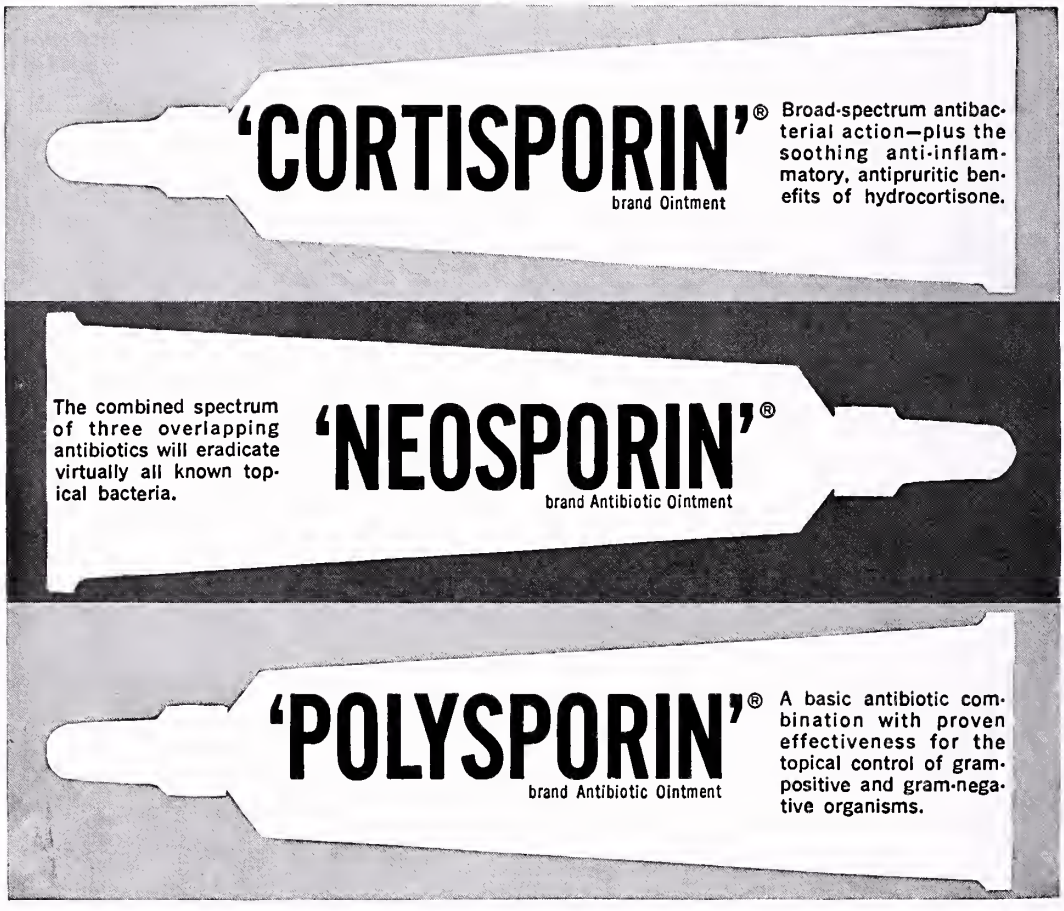
Swartz, H., "Clinical Evaluation of a New Drug (Algic) in the Symptomatic Therapy of Perennial Allergic Coryza," Current Therapeutic Research, 2 : 1960.

Each scored tablet contains: 3 mg. Chlorpheniramine Maleate; 50 mg. Phenyltoloxamine DHC; 25 mg. Racephedrine HCl.

Dosage: Adults: One or two tablets every four hours. Children (6 to 12 years): One-half adult dose.

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Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

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SQUIBB HYDROXYPROGESTERONE CAPROATE

Improved Progestational Therapy



Garden City, N. Y.



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DELALUTIN offers these advantages over other progestational agents

• long-acting sustained therapy • more effective in producing and maintaining a completely matured secretory endometrium • no androgenic effect • more concentrated solution requiring injection of less vehicle • unusually well-tolerated, even in large doses • fewer injections required • low viscosity makes administration easy

Complete information on administration and dosage is supplied in the package insert

Supply:
Vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in benzyl benzoate and sesame oil.
Also available: DELALUTIN 2X in 5 cc. multiple-dose vials. Each cc. contains 250 mg. hydroxyprogesterone caproate in castor oil, preserved with benzyl alcohol.

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COUNTY SOCIETY REPORTS

(Continued from page 96)

Dr. Arnold, Jr., presented several reasons why he felt that we should not have a United Fund Drive here in Hawaii, chiefly, that it is a matter of personal responsibility and privilege to be able to give to the agency of one's choice.

Meeting adjourned at 9:44 P.M.

* * *

The Honolulu County Medical Society met with representatives of the press on Tuesday, June 7, 1960 at 7:30 P.M. in the Mabel Smyth Auditorium.

President H. Q. Pang called the meeting to order at 7:45 P.M. Approximately 100 members and guests were present.

The following announcements were made:

New active member, Dr. Victor S. Dizon, was acknowledged.

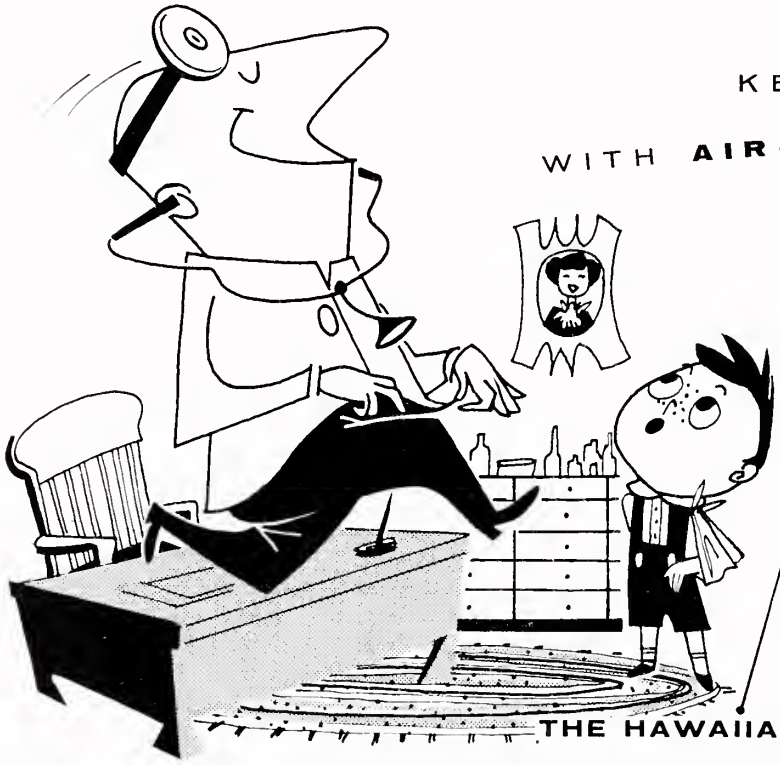
Letter from Dr. Grover H. Batten, President of the Honolulu County Medical Library, thanking the Society for its help in obtaining the appropriation for the new library.

Members were urged to cooperate with the Woman's Auxiliary in the coming 50th State Fair in which drawings by physicians' children would be shown on the subject of "My Doctor Daddy."

The following doctors were elected to serve on the Review Committee for the Federal Employees Medical Plan by HMSA: Drs. Clifford Kobayashi, Gilbert Freeman, George H. Mills, F. J. Pinkerton, H. Q. Pang, Richard Sakimoto, Sam Wallis, Alfred Burden, and S Mizuire.

Tonight's business meeting would be dispensed with

(Continued on page 106)



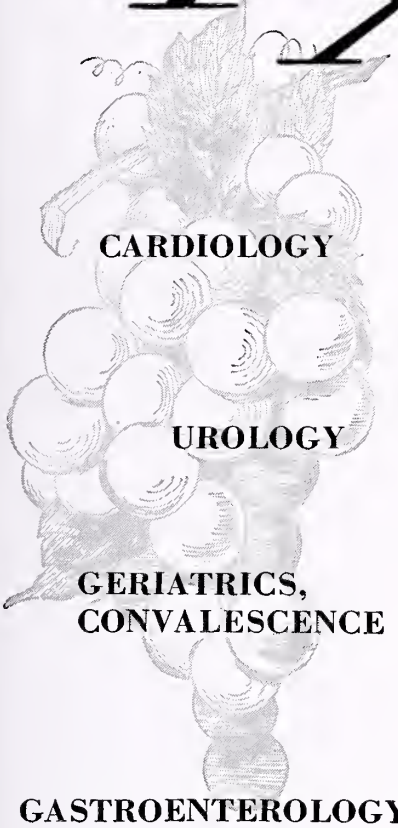
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GASTROENTEROLOGY

DIABETES

WINE has been used with excellent effect for the relief of pain, discomfort, apprehension and anxiety in angina pectoris, thromboangiitis obliterans, Raynaud's disease and hypertension.

The judicious use of WINE can brighten the otherwise monotonous, unappealing diet in renal disease. It increases glomerular blood flow, stimulates diuresis, is nonirritating to the kidneys.

By stimulating appetite, supplying quick energy source, relaxing tensions and increasing morale, the prudent use of WINE has been described as a balm for the convalescent and "milk" for the aged.

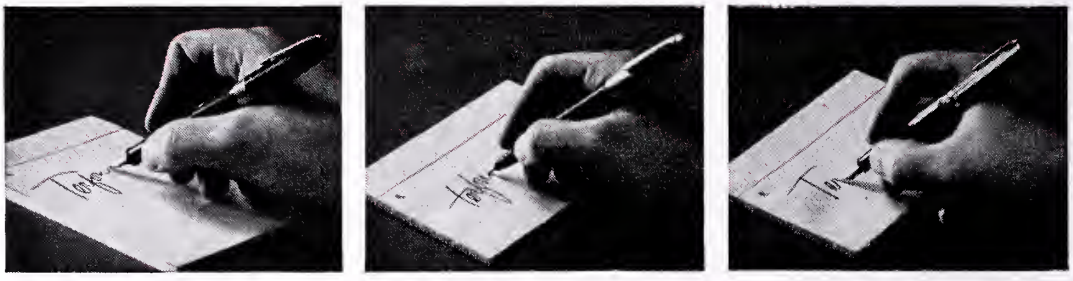
In moderate amounts WINE increases gastric secretion, relaxes gastric tension and, therefore, is a valuable aid in the treatment of anorexia, hypochlorhydria, dyspepsia, spastic constipation and diarrhea.

In the normal diet of the diabetic, WINE can serve as an excellent energy source which does not require the participation of insulin.

These and other therapeutic uses for wine are discussed in *"Uses of Wine in Medical Practice." For your free copy write—Wine Advisory Board, 717 Market Street, San Francisco 3, California.



more and more physicians are prescribing this triple sulfa



TERFONYL

Squibb Triple Sulfas (Trisulfapyrimidines)

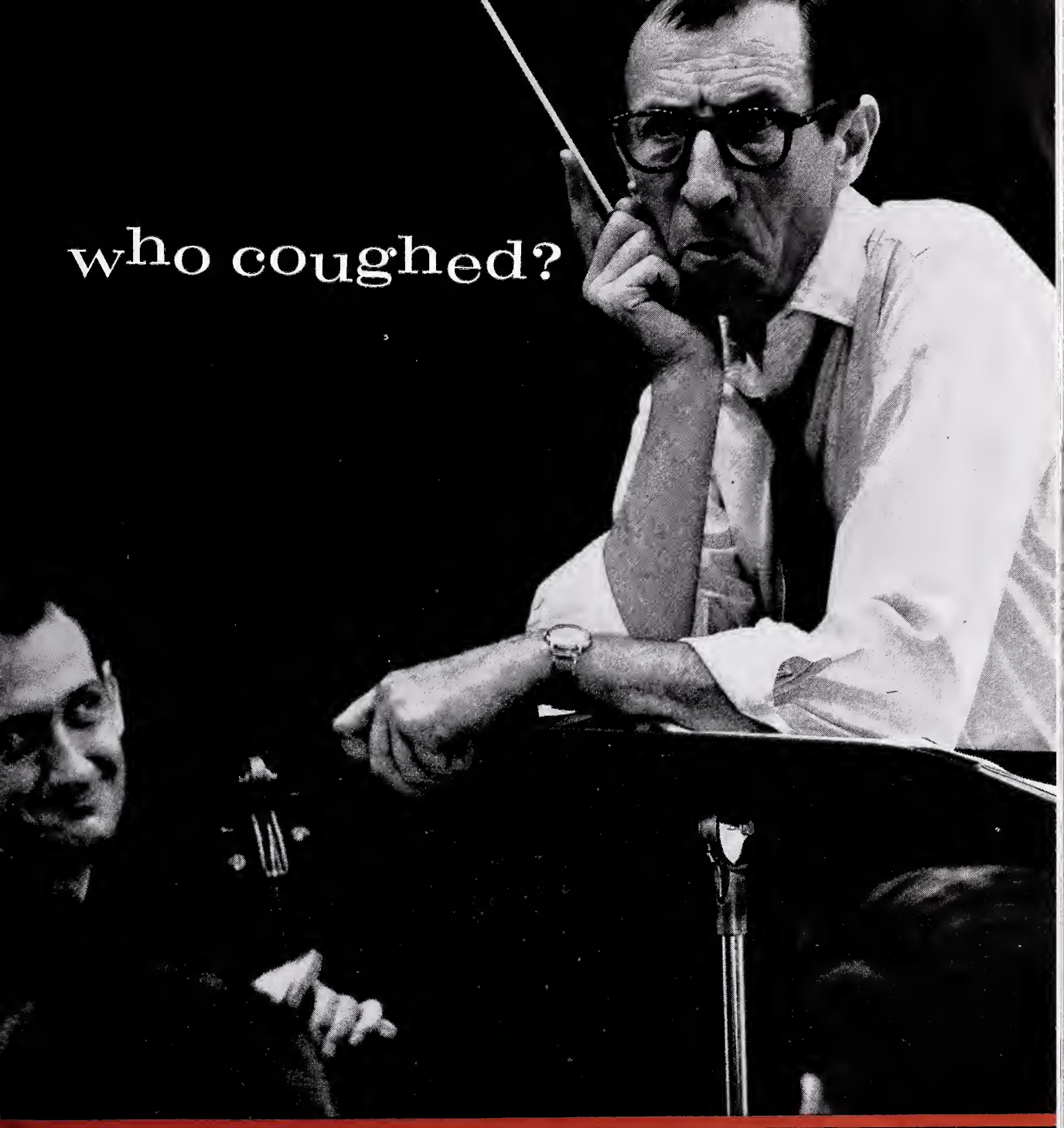
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• specificity for a wide range of organisms • superinfection rarely encountered • soluble in urine through entire physiologic pH range • minimal disturbance of intestinal flora • excellent diffusion throughout tissues • readily crosses blood-brain barrier • sustained therapeutic blood levels • extremely low incidence of sensitization

SUPPLY: Tablets, 0.5 gm. • Suspension, raspberry flavored, 0.5 gm. per teaspoonful (5cc.).

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HYCOMINE® Syrup

THE COMPLETE Rx
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cough sedative / antihistamine
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■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains:

Hycodan®		
Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law permits oral prescription.

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A DEMEROL® dosage form for every type of PAIN

DEMEROL
HYDROCHLORIDE .... *for prompt and prolonged control of severe pain*

AMPULS 1 cc. (50 mg.) 1.5 cc. (75 mg.) and 2 cc. (100 mg.)
VIALS 30 cc. (50 mg./cc.)
TABLETS 50 mg. and 100 mg.
ELIXIR (50 mg. per teaspoonful)

A.P.C. WITH **DEMEROL** .... *for less severe pain*

TABLETS containing aspirin 200 mg.
phenacetin 150 mg.
caffeine 30 mg.
Demerol HCl 30 mg.

DEMEROL WITH **SCOPOLAMINE** .... *for preoperative medication, obstetric analgesia and amnesia*

Each 1 cc. contains 50 mg. Demerol HCl and
0.2 mg. (1/300 grain) scopolamine HBr.

DEMEROL WITH **ATROPINE** .... *for preoperative use, gastro-intestinal, biliary and renal colic, acute cardiospasm and pylorospasm*

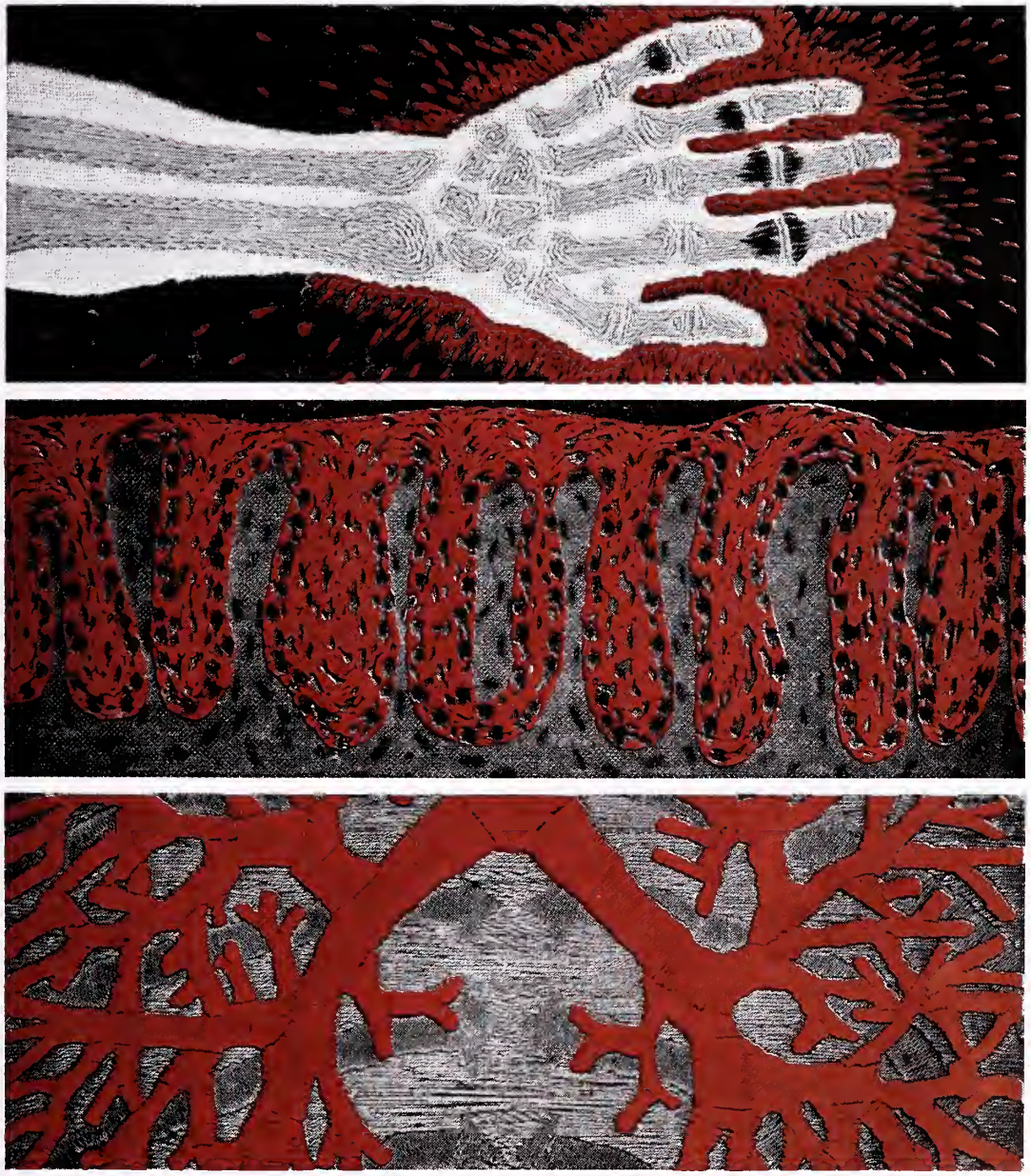
Each 1 cc. contains 50 mg. Demerol HCl and
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SURGICAL INSTRUMENTS

ORTHOPEDIC EQUIPMENT EXAMINING ROOM EQUIPMENT

COUNTY SOCIETY REPORTS

(Continued from page 100)

in view of the many guests present and that a special membership meeting would be held June 21, 7:30 P.M., to discuss the Medical Care Plans Committee's recommendations re HMSA contract.

A panel discussion was held on "Better Medical Press Relations" followed by a questions and answer period.

The moderator was Hal (J. Aku Head Pupule) Lewis. Panelists were Bud Smyser, *Star-Bulletin;* Buck Buchwach, *Advertiser;* William H. Stevens, M.D.; and William M. Walsh, M.D.

The meeting was adjourned at 9:45 P.M.

O. D. PINKERTON, M.D.
Secretary

Kauai

A special meeting of the Kauai County Medical Society was held on April 12, 1960, after the Wilcox Hospital staff meeting. It was called for the purpose of discussing the problems of medical indigent care. Present were all doctors of the Kauai County Medical Society except Dr. Fujii, and the following guests; Miss Mary Noonan, Mr. Lawrence Nakatsuka, Mr. Francis Ishida, and Mr. James Nakao.

The staff of the Department of Social Services of Hawaii discussed the problems of indigent medical care. No definite conclusion or recommendations were made.

MARVIN A. BRENNECKE, M.D.
Secretary



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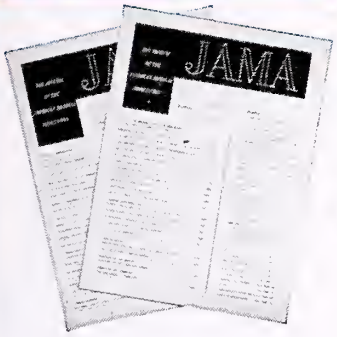
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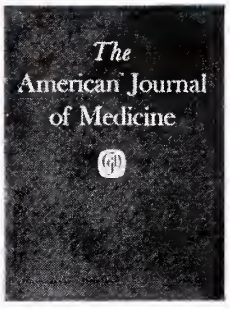
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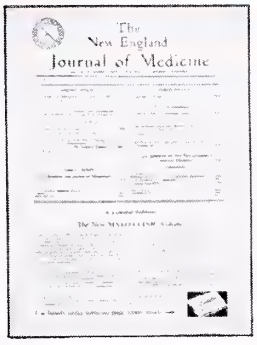
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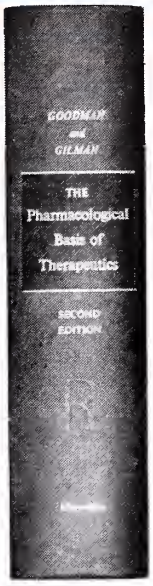
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Both folic acid and B_{12} have been omitted from Adabee, in recognition of this growing medical concern. Also excluded are other factors which might interfere with concurrent therapy, such as, hormones, enzymes, amino acids, and yeast derivatives. Adabee supplies massive doses of therapeutically practical vitamins for use in both specific and supportive schedules in illness and stress situations. Thus, new Adabee offers the therapeutic advantage of sustained maximum multivitamin support without the threat of symptom-masking.

references: 1. Wintrobe, M. M., *Clinical Hematology*, 3rd ed., Phila., Lea & Febiger, 1952, p. 398. 2. Goodman, L. S. and Gilman, A., *The Pharmacological Basis of Therapeutics*, 2nd. ed., New York, Macmillan, 1955, p. 1709. 3. New Eng. J.M., Vol. 259, No. 25, Dec. 18, 1958, p. 1231. 4. Frohlich, E. D., New Eng. J.M., 259:1221, 1958. 5. J.A.M.A., 169:41, 1959. 6. J.A.M.A., 173:240, 1960. 7. Goldsmith, G. A., American J. of M., 25:680, 1958. 8. Darby, W. J., American J. of M., 25:726, 1958.

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Each yellow, capsule-shaped tablet contains:

Vitamin A	25,000 USP units
Vitamin D	1,000 USP units
Thiamine mononitrate (B_1)	15 mg.
Riboflavin (B_2)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Nicotinamide (niacinamide)	50 mg.
Calcium pantothenate	10 mg.
Ascorbic acid (vitamin C)	250 mg.

ADABEE® M

Each green, capsule-shaped tablet contains Adabee plus nine essential minerals:

Iron	15.0 mg.	Zinc	1.5 mg.
Iodine	0.15 mg.	Potassium	5.0 mg.
Copper	1.0 mg.	Calcium	103.0 mg.
Manganese	1.0 mg.	Phosphorus	80.0 mg.
Magnesium	6.0 mg.		

indications: As dietary supplements for the deficiency states that accompany pregnancy and lactation, surgery, burns, trauma, alcohol ingestion, hyperthyroidism, infections, cardiac disease, polyuria, anorexia, cirrhosis, arthritis, colitis, diabetes mellitus, and degenerative diseases. Also in restricted diets, particularly peptic ulcer, in geriatrics, and in concurrent administration with diuretics and antibiotics.

dosage: One or more tablets a day, as indicated, preferably with meals.

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the multivitamin without B_{12} or folic acid

A. H. ROBINS COMPANY, INC.

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BOOK REVIEWS

(Continued from page 67)

orators bringing their specialized knowledge in rather concise and practical form suitable for the practicing clinician who needs to know the puzzling facets of the many illnesses confronting him not only in the climatic zones but the economically depressed areas of the world.

The disease discussed are not exclusively tropical nor always predominantly so. I was surprised to find a section on virus diseases as well as tuberculosis. This text is widely illustrated with photographs. Maps show the distribution of important diseases. Tables of vectors, culturing characteristics, and features of identification of parasites enable the doctor to carry on without trained technicians should this be necessary. A section on laboratory methods and procedures is a good reference for the gathering of specimens as well as for the actual laboratory testing.

Today with our increasingly greater communication and more rapid air travel to all parts of the world, the exotic diseases will occasionally appear in our midst and this text is the one I would choose for ready reference. Unfortunately there is no bibliography.

C. D. BROWN, M.D.

Also Received

Baby Name Finder

By J. E. Schmidt, M.D., 390 pp., $10.50, Charles C. Thomas, 1960.

How have we been able to get along so well without this lexicon of names? Fun for the obstetrician to ha it around.

CIBA Foundation Colloquia on Aging, The Lifespan of Animals

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M. B.Ch., 324 pp., $2.50, Little & Brown, 1960.

Fascinating—especially the discussions.

CIBA Foundation Symposium on Biochemisti of Human Genetics

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.I B.Ch., 338 pp., $2.50, Little & Brown, 1960.

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CIBA Foundation Edition, From Fish to Philosopher

By Homer W. Smith, 304 pp., $2.50, Little, Brown Co., 1960.

A thoughtful, readable history of man's evolution a the stages by which a kidney freed him from the se

British Medical Bulletin, Vol. 16, No. 2

N. B. Myant, Scientific Editor, pp. 89-174, May, 1960.

The papers contained in this symposium deal with the aspects of research on the thyroid gland togeth with several others of a more specialized character.

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1. Rein, C. R., and Fleischmajer, R.: The efficacy of tetracycline phosphate complex (TETREX) in dermatological therapy. Antibiotic Med. & Clin. Ther. 4:422 (July) 1957.

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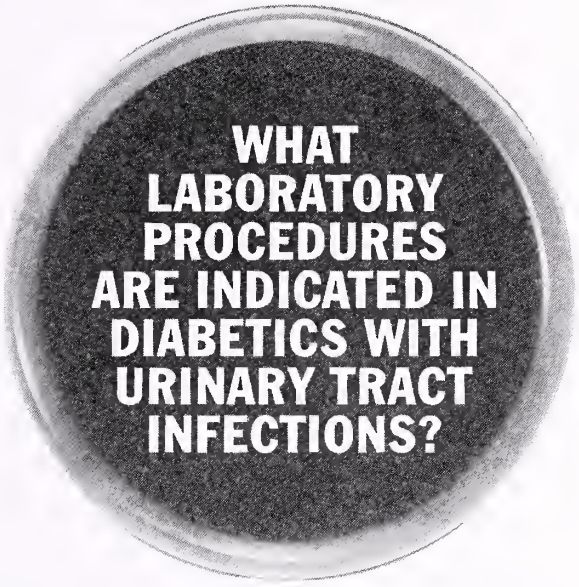
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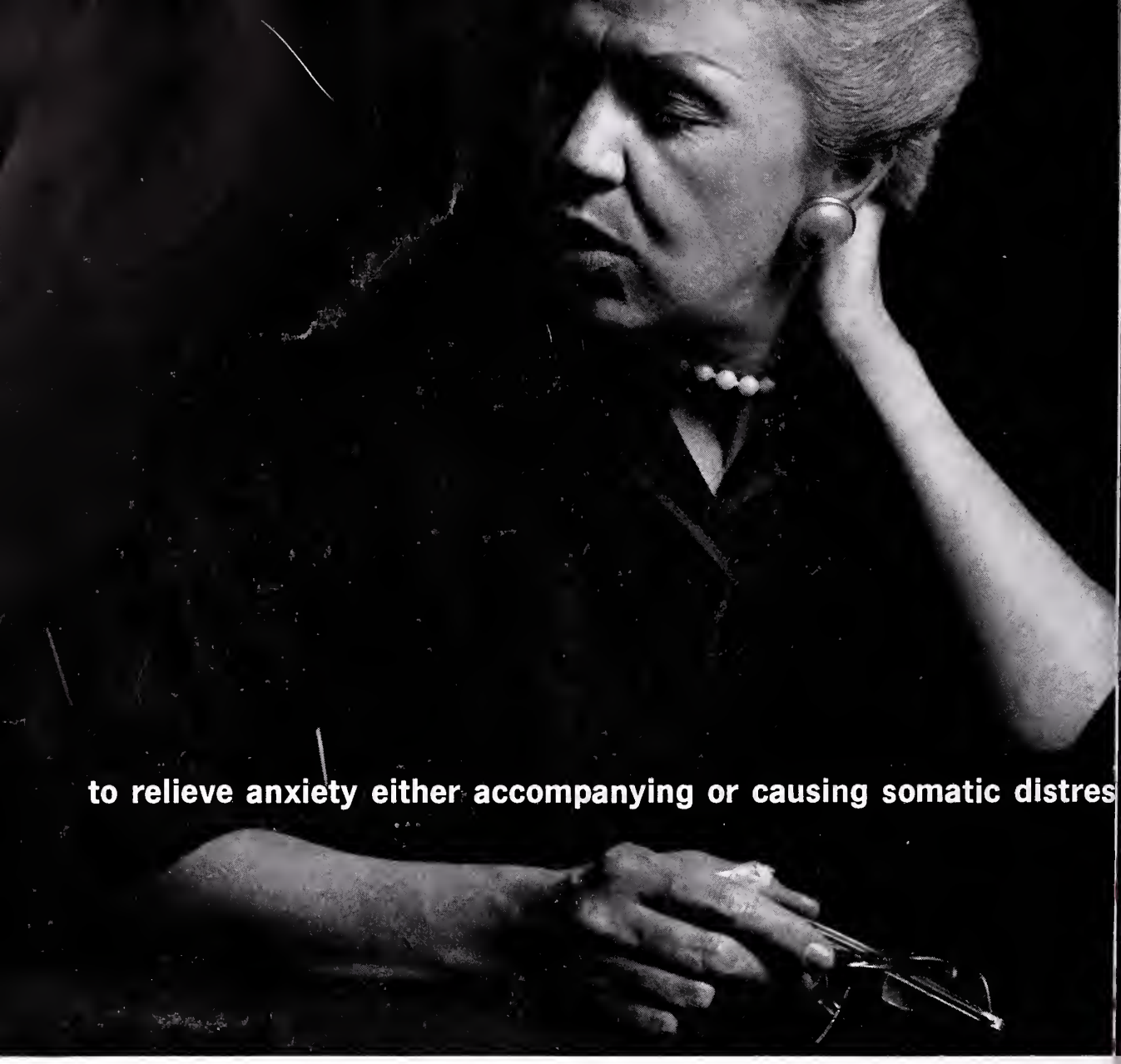
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1. Marx, F.J., in *Trifluoperazine: Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959, p. 89.
2. Winkelman, N.W., Jr.: *ibid.*, p. 78.

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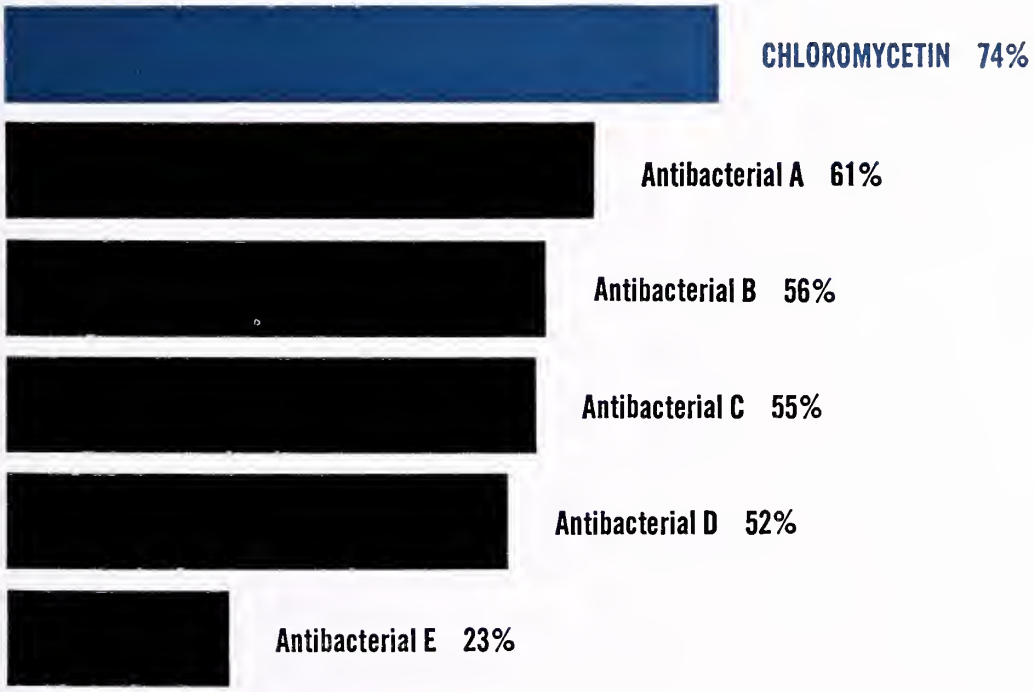
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COUNTY SOCIETY REPORTS

(Continued from page 206)

itation. He then introduced the members of the Rehabilitation Team and the meeting was turned over to Dr. Leon Lewis who headed the Institute.

Dr. Lewis stressed the importance of convalescent care in rehabilitation so that the patient can be returned to normalcy. He further urged that the County of Maui set up a definite rehabilitation program in the treatment of disabled patients just as we have in the treatment of acute illnesses.

Following this, five cases were presented of which two were rheumatoid arthritis, one quadriplegic, one paraplegic, and one hemiplegic. After presentation of each case, Dr. Lewis followed it with a very informative and enlightening discussion.

* * *

A special dinner meeting of the Maui County Medical Society was held at the Maui Hukilau Hotel on May 5, 1960, hosted by the H.M.S.A. H.M.S.A. members attending were: Mr. Oliphant, Dr. Faus, Dr. Richard Sakimoto, Mr. Veltmann, Mr. Yuen, and Mrs. Smith. Guests were the members of the Medical Society Auxiliary.

Following the dinner, the H.M.S.A. officials presented an up-to-date report for the year 1959. Mr. Veltmann and Mr. Yuen reported on the Federal employees medical service insurance and were happy to report that H.M.S.A. will qualify under 4-b.

Dr. Kliewer's application for active membership in the Maui County Medical Society was approved unanimously.

President Wong appointed Dr. Mark Sowers delegate to the HMA meeting to be held May 12-15, 1960.

* * *

A special meeting of the Maui County Medical Society was called to order at 9:10 P.M. by President A. Y. Wong on July 14, 1960, at the Central Maui Memorial Hospital.

A letter from Chairman Tam was read regarding the appointment of one trustee from the Maui County Medical Society. He requested three names, one to be chosen as a trustee. Dr. Burden moved that Doctors McArthur, Patterson, and Shimokawa be considered. Because of the lack of a second, the motion died. Dr. Moran moved that Doctors Burden, Moran, and Iaconetti be considered. The motion was seconded by Dr. Fleming and passed.

* * *

A short special meeting was called on August 18, 1960 by the President Dr. A. Y. Wong, for the purpose of discussing the discrepancy between U. S. Life and H.M.S.A. fee schedules. It was moved by Dr. Fleming that the secretary be instructed to write a letter to the Union U. S. Life and the other medical societies that the members of the Maui County Medical Society will charge current H.M.S.A. fees. It was seconded by Dr. Shimokawa. There were eight in favor of the motion and ten against. Then, Dr. McArthur moved that the Medical Society, as a group, request U. S. Life to bring their fee schedule up to that of the current H.M.S.A. fee schedule and that copies of this letter be sent to H.M.S.A. and the other Medical Societies. It was seconded by Dr. Sowers and passed unanimously.

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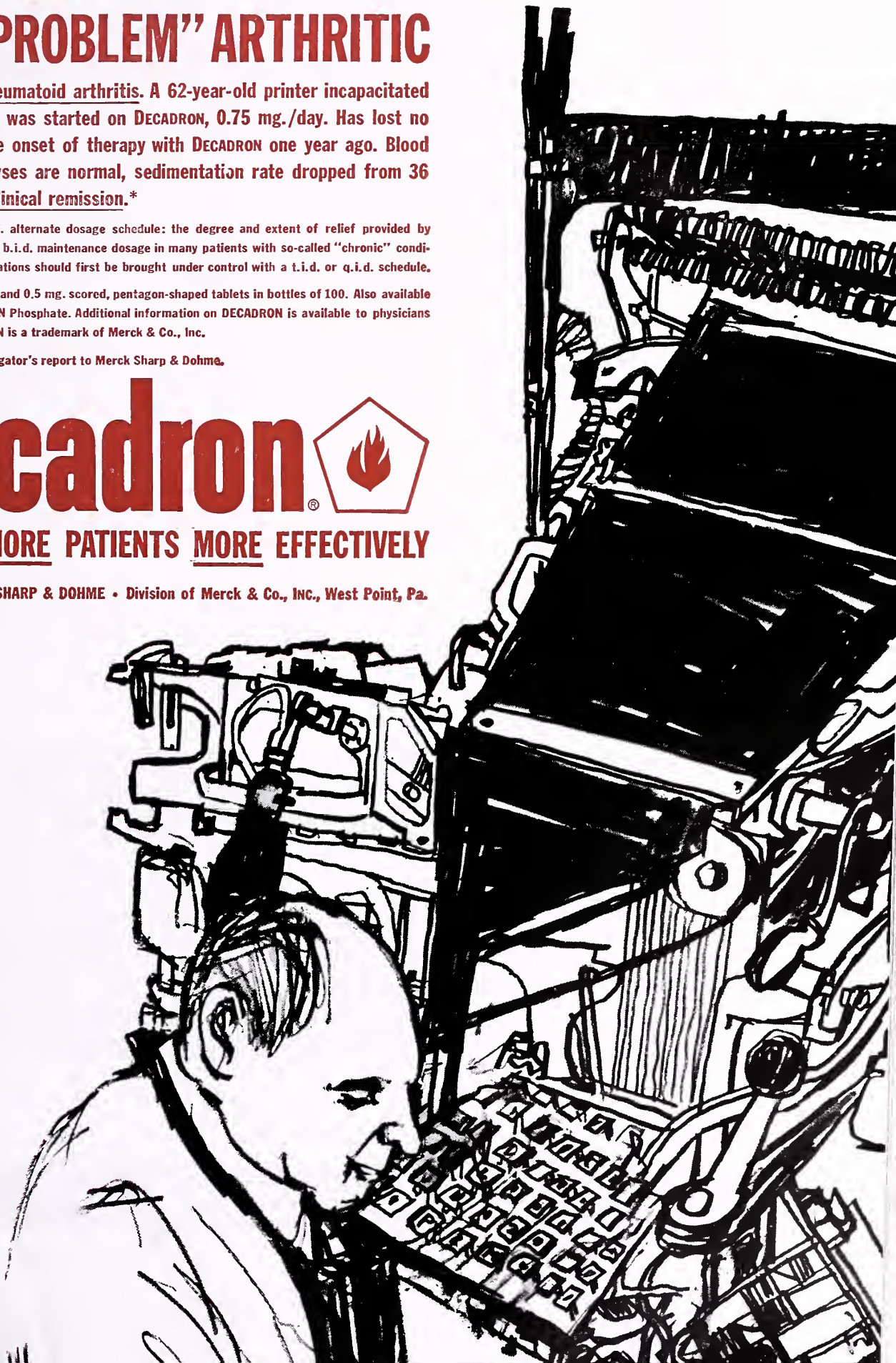
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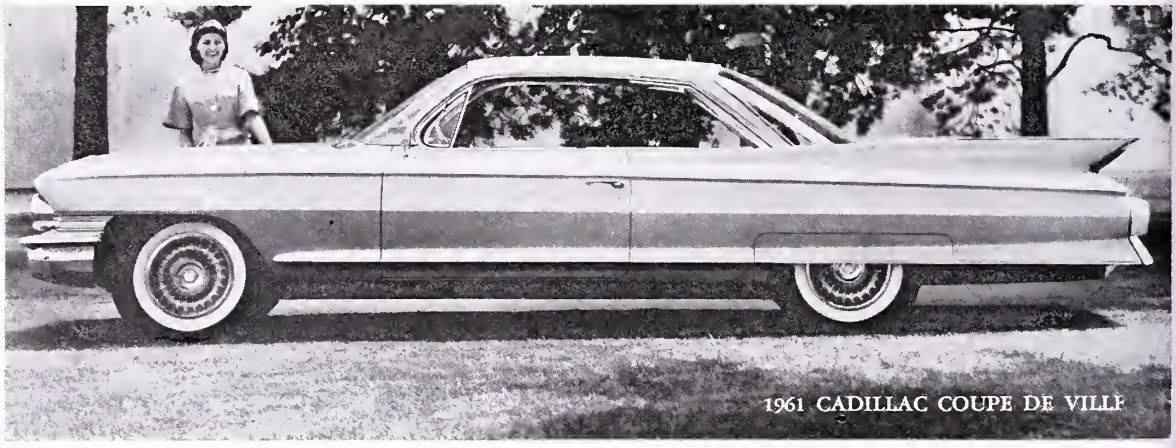


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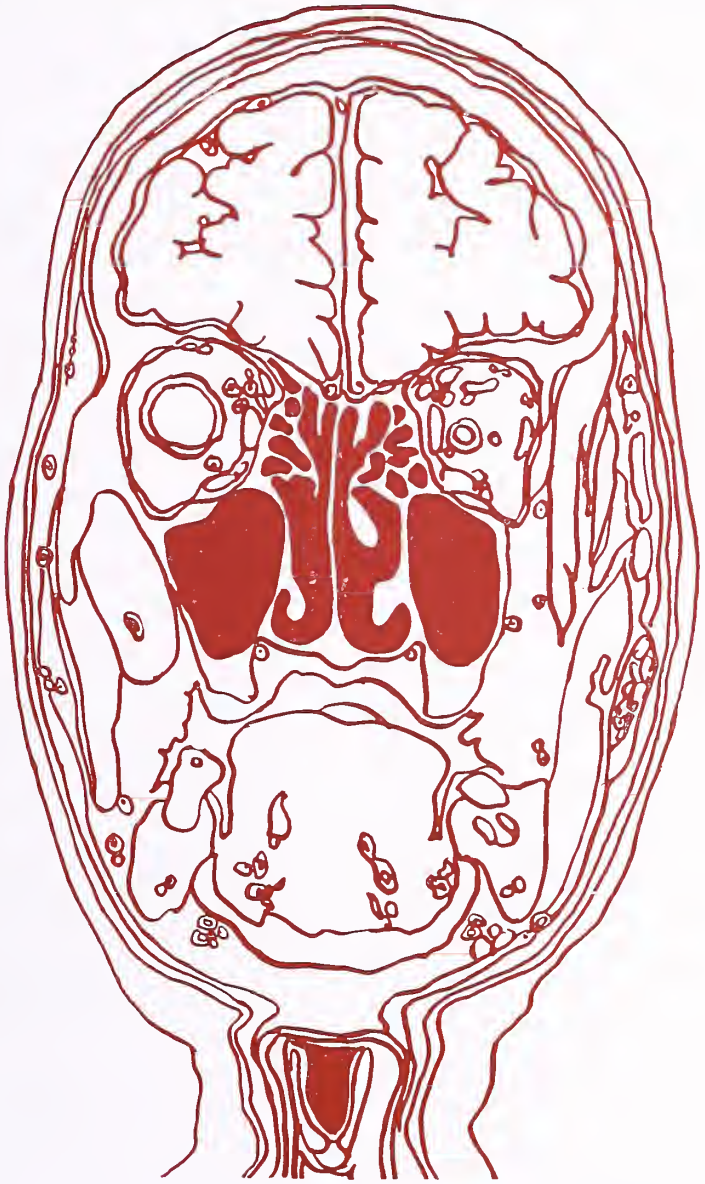
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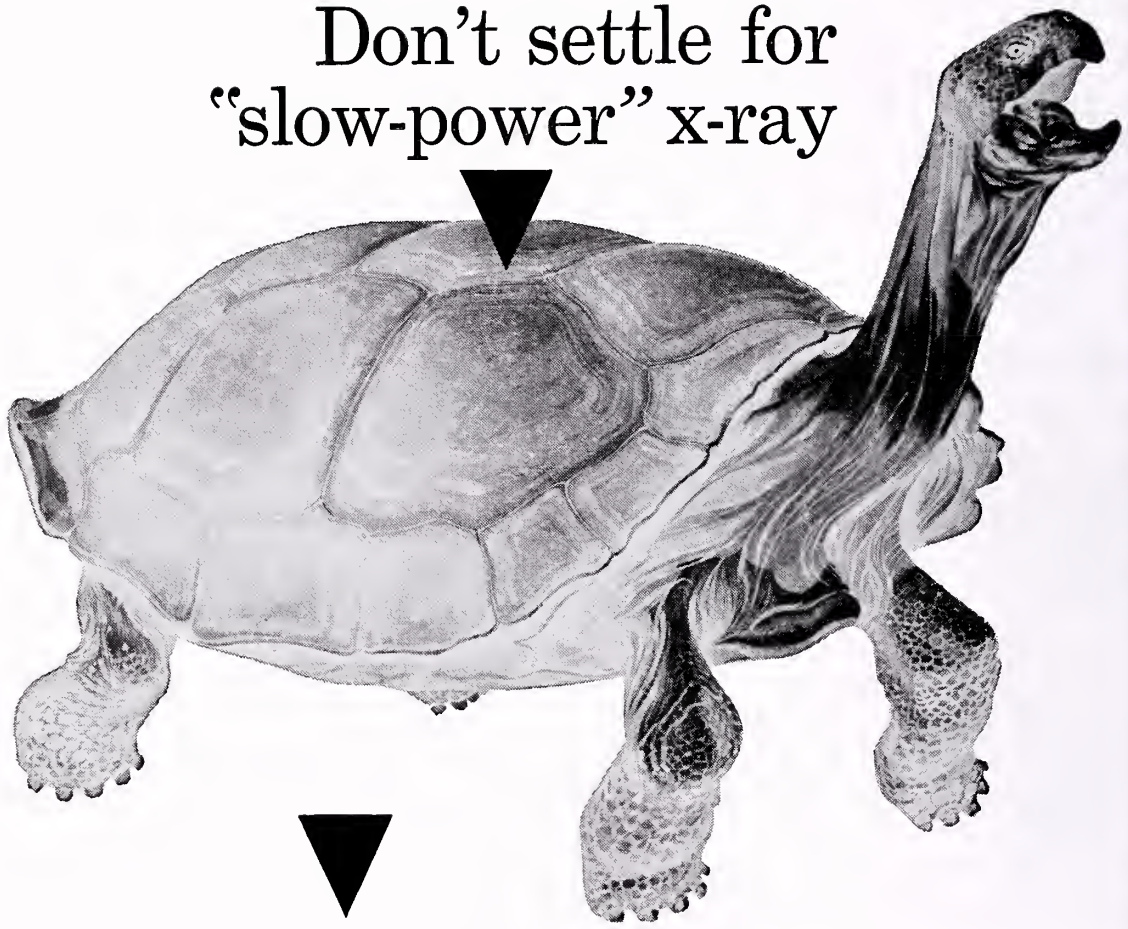
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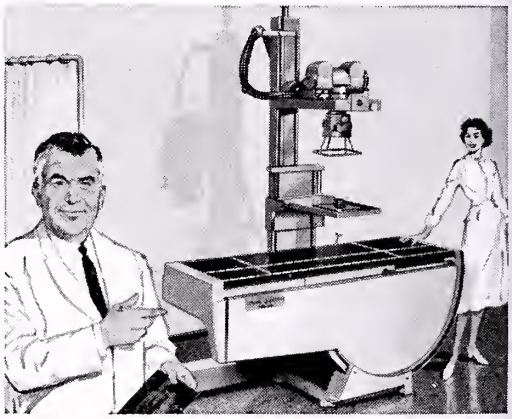
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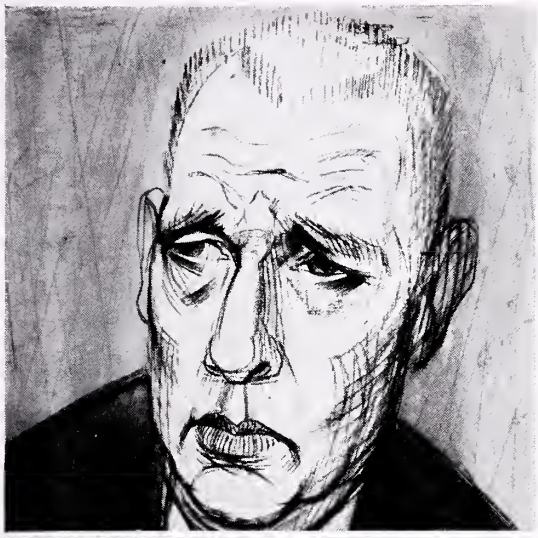
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now—for more comprehensive control of *'pain & spasm'*



INDICATIONS

HEAD: temporomandibular muscle spasm • NECK: acute torticollis, osteoarthritis of cervical spine with spasm of cervical muscles, whiplash injury • TRUNK AND CHEST: costochondritis, intercostal myositis, xiphodynia • BACK: acute and chronic lumbar strains and sprains, acute low back pain (unspecified), acute lumbar arthritis and traumatic injury, compression fracture, herniated intervertebral disc, post-disc syndrome, strained muscle(s) • EXTREMITIES: acute hip injury with muscle spasm, ankle sprain, arthritis (as of foot or knee), blow to shin followed by muscle spasm, bursitis, spasm or strain of muscle or muscle group, old fracture with recurrent spasm, Pellegrini-Stieda disease, tenosynovitis with associated pain and spasm.

-pain due to or associated with -spasm of skeletal muscle

a new muscle relaxant-analgesic



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ROBAXIN® WITH ASPIRIN

Many conditions, painful in themselves, often give rise to spasm of skeletal muscles. ROBAXISAL, the new dual-acting muscle relaxant-analgesic, treats both the pain and the spasm with marked success: In clinical studies on 311 patients, 12 investigators[1] reported satisfactory results in 86.5%. Each ROBAXISAL Tablet contains:

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. . . or when anxiety accompanies pain and spasm: ROBAXISAL®-PH (Robaxin® with Phenaphen®). Sedative-enhanced analgesic and skeletal muscle relaxant. Each two white-and-green laminated ROBAXISAL-PH tablets contain: methocarbamol 800 mg., plus the equivalent of one Phenaphen capsule (phenacetin 194 mg., acetylsalicylic acid 162 mg., hyoscyamine sulfate 0.031 mg., and ¼ gr. phenobarbital 16.2 mg.). Bottles of 100 and 500.

[1]Clinical reports in files of A. H. Robins Co., Inc., from: J. Allen, Madison, Wisc., B. Billow, New York, N. Y., B. Decker, Richmond, Va., C. Freeman, Jr., Augusta, Ga., R. B. Gordon, New York, N. Y., J. E. Holmblad, Schenectady, N. Y., L. Levy, New York, N. Y., N. LoBue, Chicago Heights, Ill., H. Nachman, Richmond, Va., A. Poindexter, Los Angeles, Cal., E. Rogers, Brooklyn, N. Y., K. H. Strong, Fairfield, Ia.

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References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

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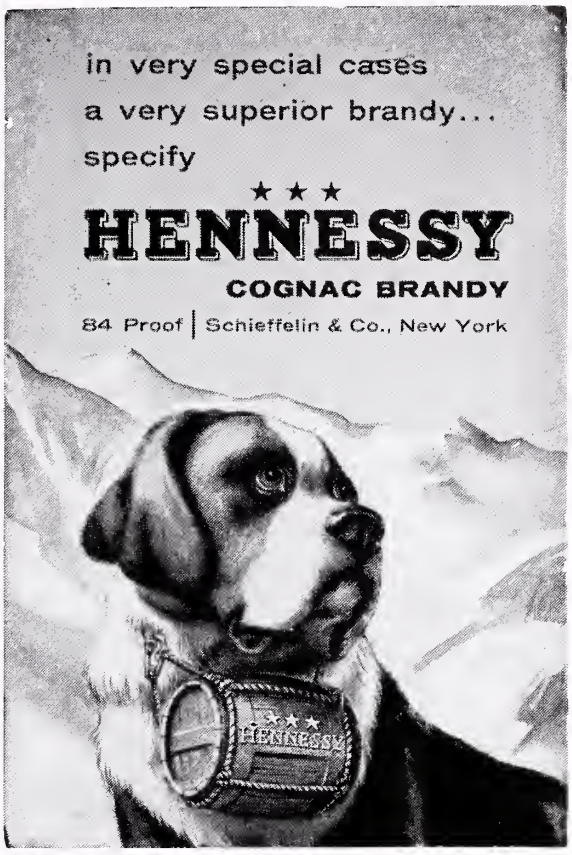
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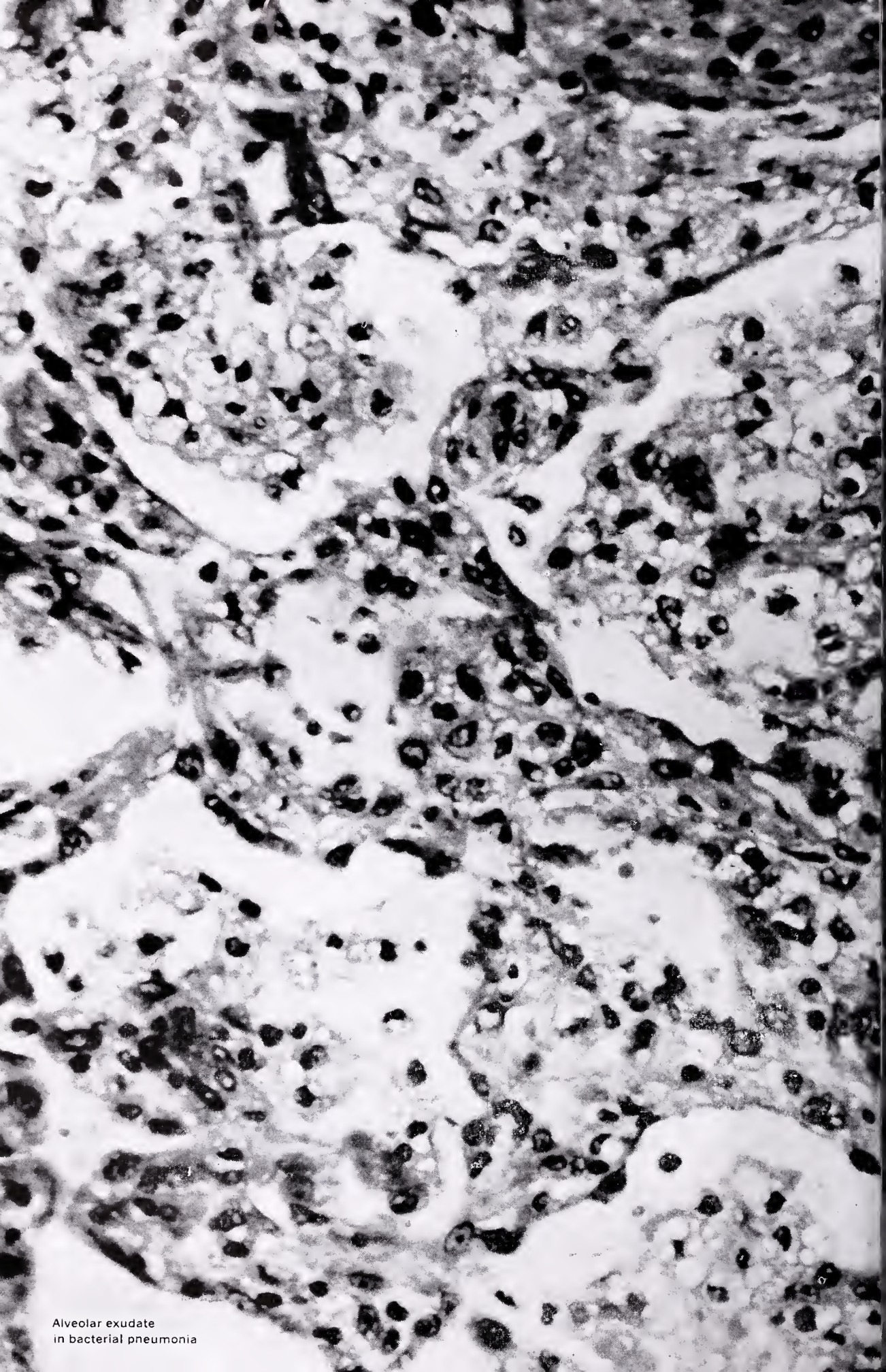
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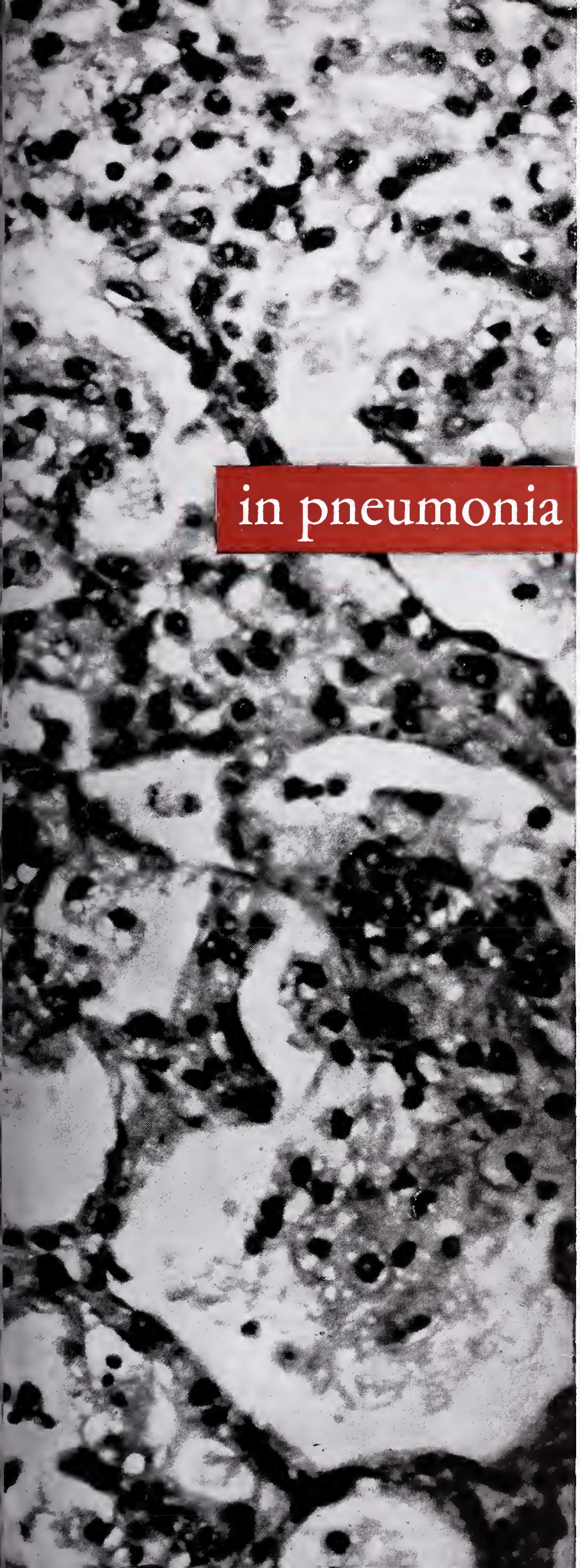
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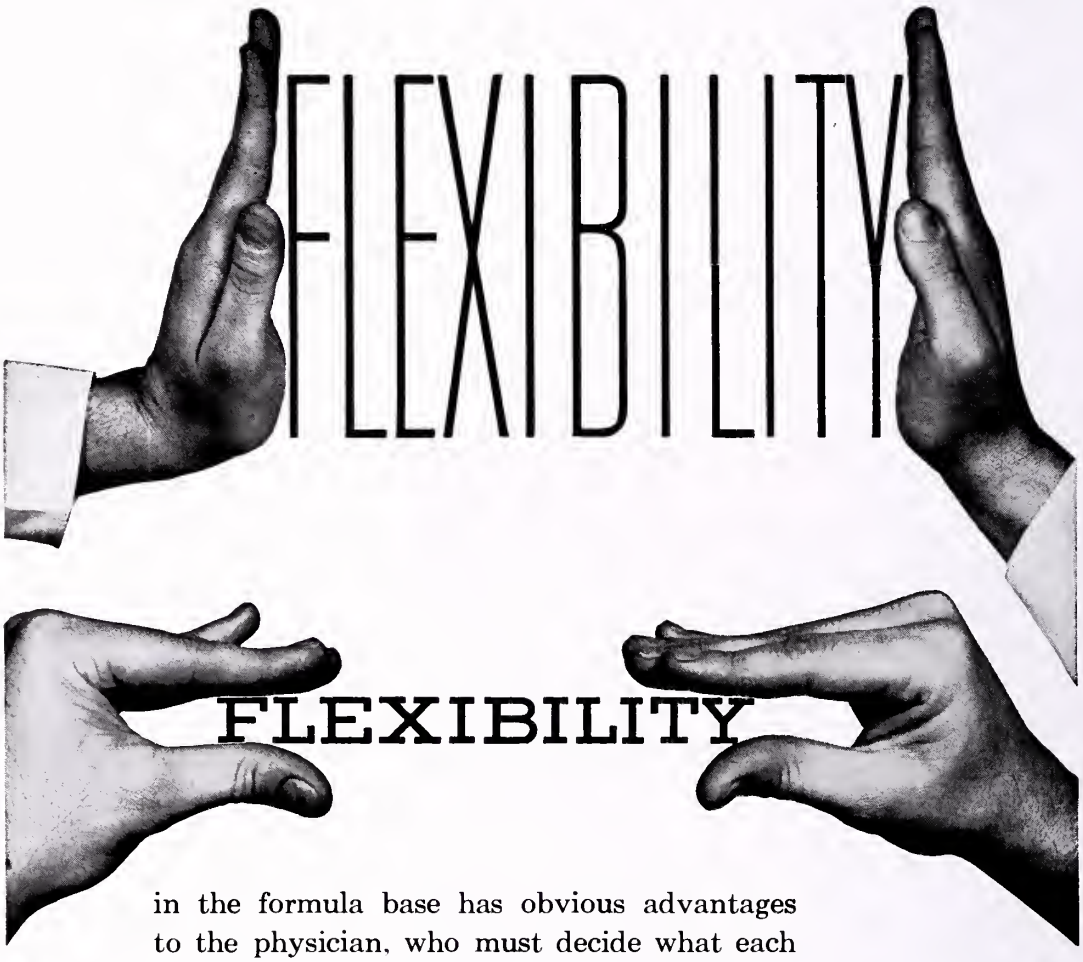
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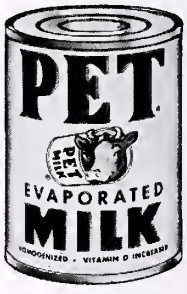


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SUMMIT, N. J.

Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955. /2830M6

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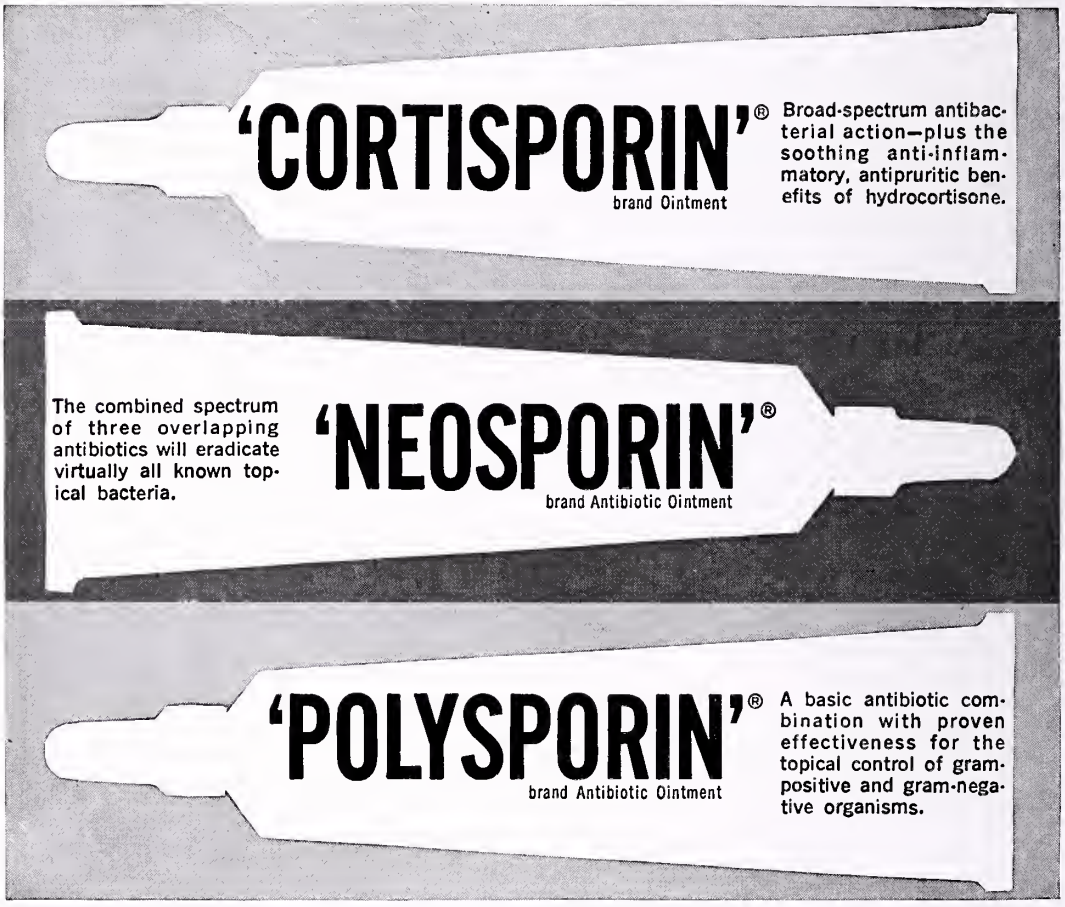
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1. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

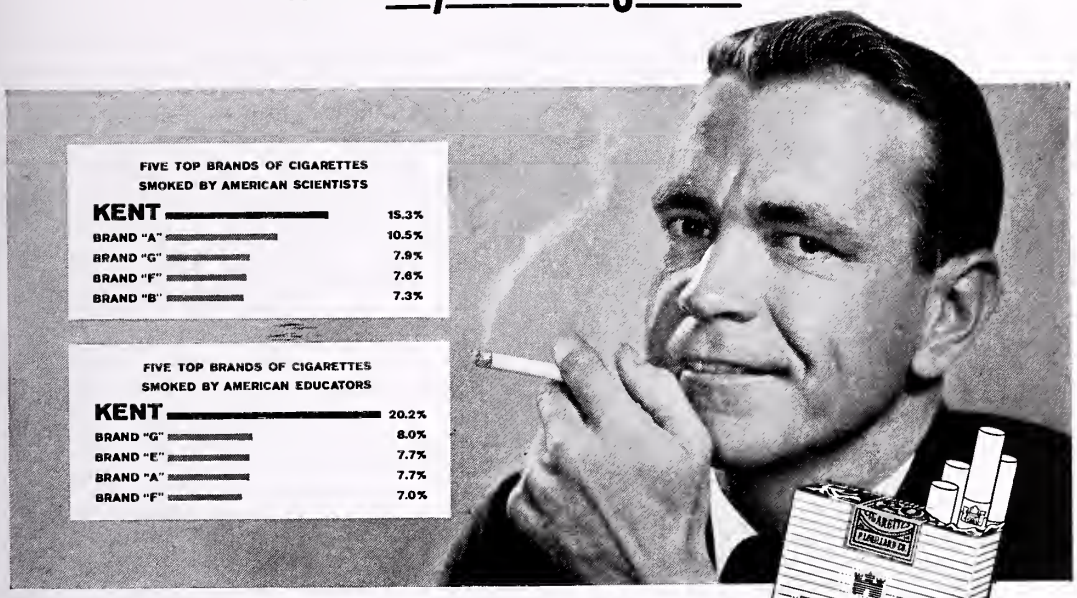
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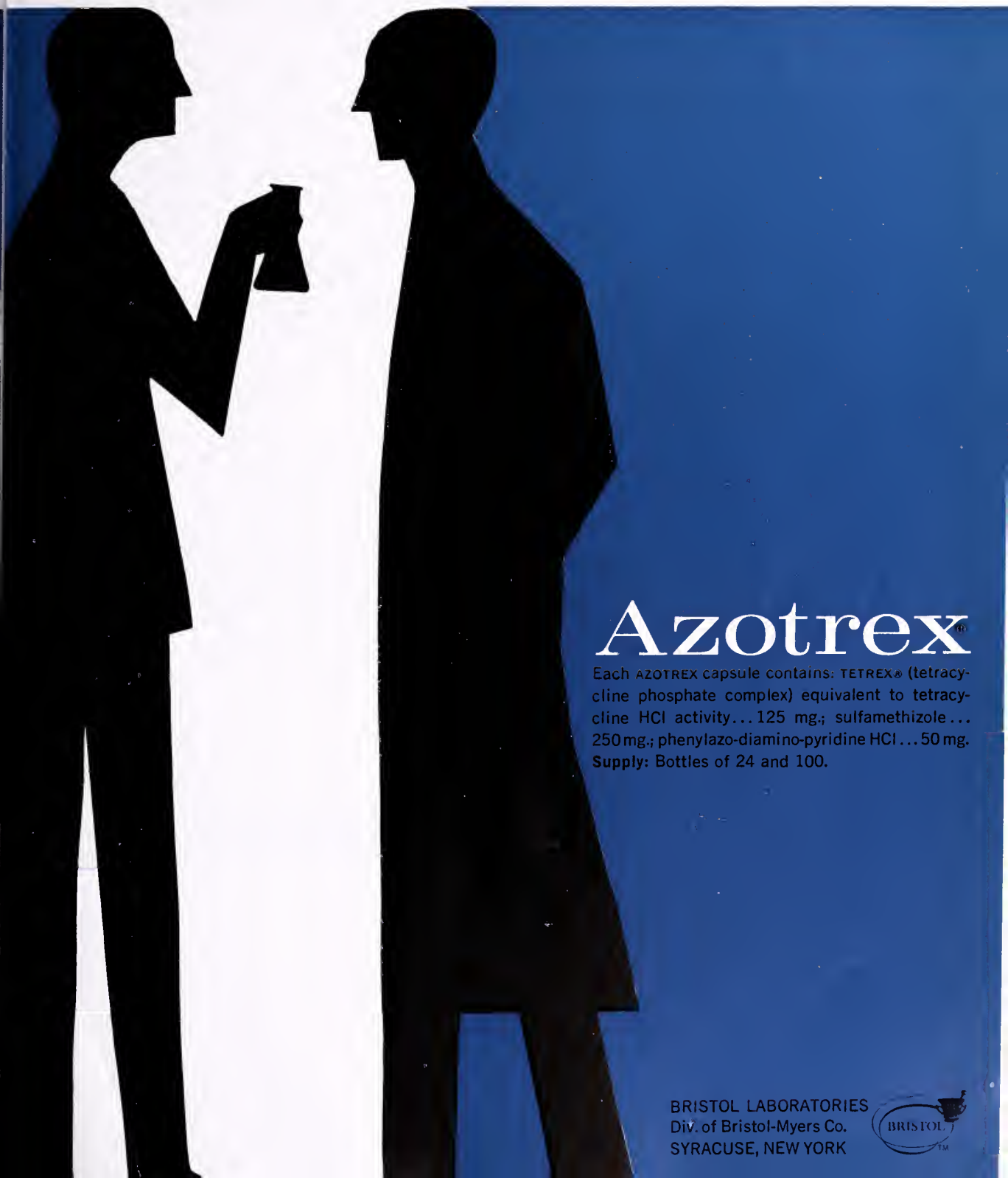
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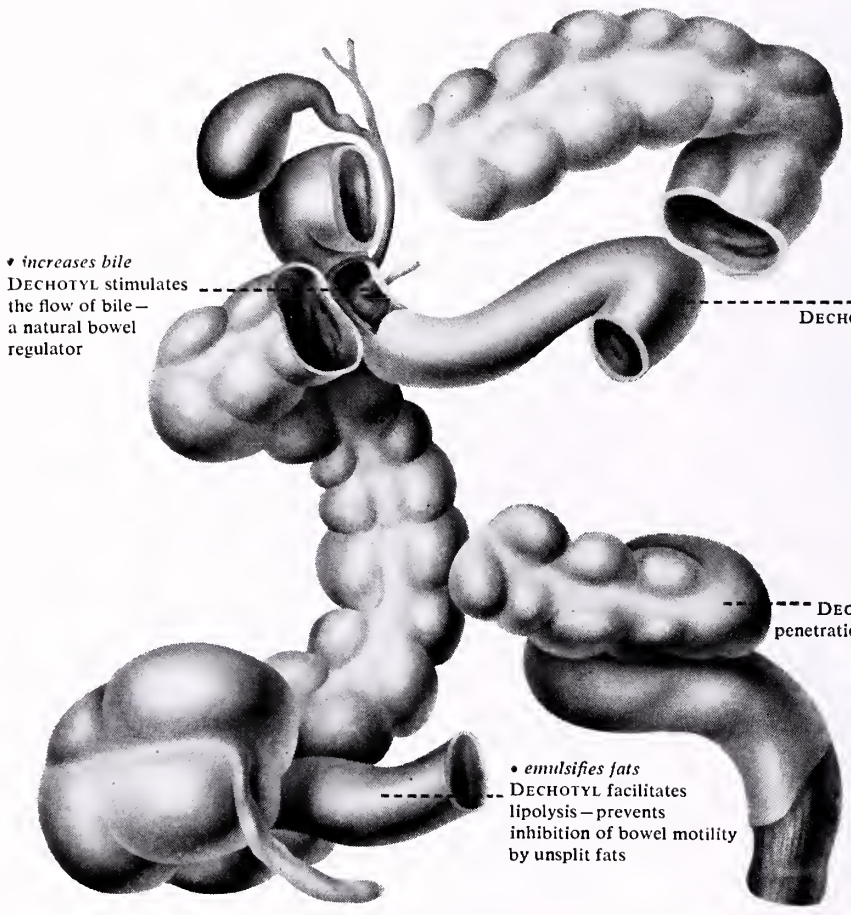


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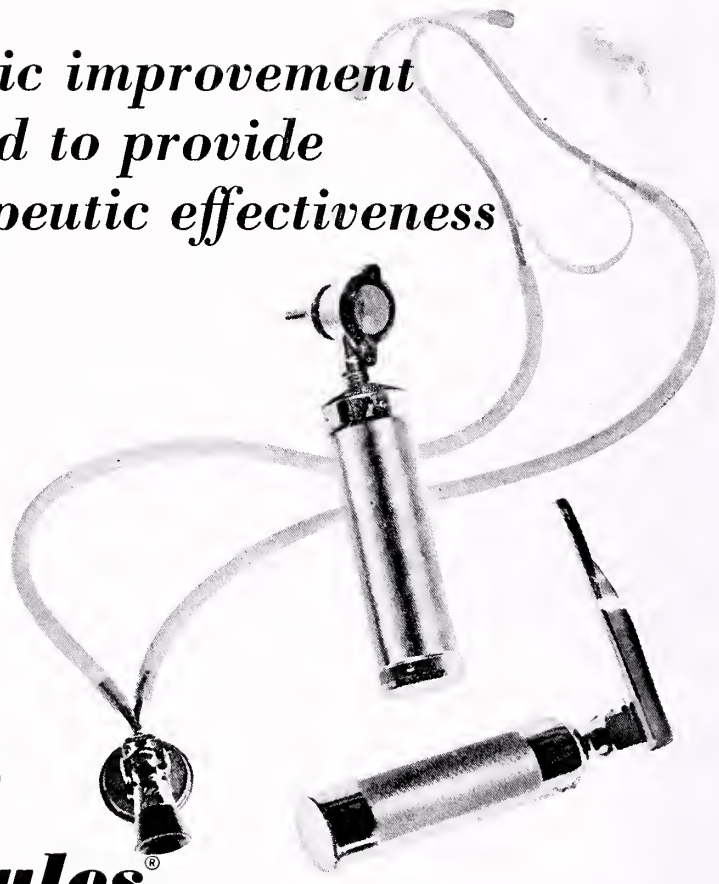


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One in five fifth-grade children on Oahu has a visual defect of some kind.
One in seven has a refractive error; of these, over half wear glasses.

School Health Services Evaluation Study

Part 2: Eye Examinations

KATHERINE J. EDGAR, M.D., ROBERT A. SPICER, Ph.D.,
and VERNON K. S. JIM, M.D., Honolulu

THIS REPORT is an analysis of the eye and vision examinations of selected Oahu school children. It is the second in a series of papers on the findings of the School Health Services Evaluation Study, sponsored by the Oahu Tuberculosis and Health Association, and conducted in 1957-1958. Multiphasic examinations were given to a representative sample of fifth-grade school children from 31 schools on the island of Oahu.[1] The sample included 1,064 students (573 boys and 491 girls.)



DR. EDGAR

All the visual acuity and color vision screening was done by a well trained and experienced worker from the Bureau of Sight Conservation[2] (Miss Margaret Fujita). Each of the students was then seen by the ophthalmologist (Dr. Vernon K. S. Jim) for a complete eye evaluation.

The eye examinations were standardized by equipment, technique, and recording methods. Examinations consisted of three parts carried out in the following sequence:

(1) Visual acuity by means of the Snellen E test chart, with and without glasses, under standard conditions of illumination.
(2) Color blindness testing by means of the American Optical HRR Pseudoisochromatic color plates.
(3) Ophthalmological examinations.

Classification Method

All defects and related conditions were classified by degree and correctability. Table 1 shows severity and status scales used in classification. This arbitrary system was devised to provide comparative values and measures between the several kinds of examinations given. Operational definitions will be given with the description of each of the three major parts of the vision examination. Each examiner had to make professional judgments regarding observed conditions and despite some obvious limitations the methods employed provided an essential medium of communication and comparisons.

TABLE 1.—*Classification System*

SEVERITY	STATUS
..... Not Remarkable	..... Correctable
..... Incomplete Diagnosis	..... Partially Correctable
..... Health and Adjustment Handicap	..... Not Correctable
..... Potential Handicap	..... Partially Corrected
..... Acute Condition	..... Corrected
..... Minor	

Received for publication July 29, 1960.

[1] Edgar, K. J., and Spicer, R. A.: Preliminary report of school health services evaluation study, HAWAII MED. J. 299:304 (Jan.-Feb.) 1960.

[2] Will be referred to as BSC in remainder of paper.

TABLE 2.—*Number of Students and Degree of Visual Acuity Loss Without Glasses*

VISION WITHOUT GLASSES	VISUAL ACUITY LOSS IN ONE EYE ONLY (OTHER EYE 20/20 OR 20/25)	VISUAL ACUITY LOSS IN BOTH EYES		TOTAL
		Same Loss in Both Eyes	*Different Loss in Each Eye**	
20/30	28	11	15	54
20/40	13	11	17	41
20/50	3	1	4	8
20/60	0	0	0	0
20/70	2	8	8	18
20/80	0	0	0	0
20/100	1	10	4	15
20/200	4	6	0	10
Total	51	47	48	146
20/20 or 20/25 in both eyes				918
			Total	1,064

* Classified according to better eye.

Visual Acuity

One hundred forty-six students (64 boys and 82 girls) or 14 per cent of the 1,064 students were found to have visual acuity of 20/30 or less by means of the Snellen E test chart. All wearing glasses were re-examined on the Snellen E chart to determine the degree of correction. Forty-four students of this group, with corrective lenses, were found to have visual acuities of 20/25 or better. Seventy students with defective visual acuity did not have corrective lenses at the time of the examination.[3] All other students were considered to have normal visual acuity. Supplementary pinhole testing was done with all students having defective visual acuity.[4]

As indicated in Table 2, visual acuities of 20/30 or 20/40 constitute a majority of the visual cond tions. Ninety-five students of the 146 with visua defects fall in this group. Twenty-five student had visual acuity of 20/100 or less in one or bot eyes.

The following three categories were used t demonstrate the extent of correction with glasse The number of students with defective visual acu ity who did not have glasses at time of examina tion is also shown in the tabulation.

(1) Visual acuity of students with loss in one ey only, other eye normal (Table 3).
(2) Visual acuity of students with the same loss i both eyes (Table 4).
(3) Visual acuity of students with a different loss i each eye (Table 5).

Each of these three tables (Tables 2, 3, 4) list the visual acuity without glasses and compare these findings with the corrected visual acuity wit glasses. The 146 cases of defective visual acuit described above are further classified as to co rectability in Table 6. Of these, 76 students ha

[3] One student was found to have 20/20 vision in both eyes without glasses. Visual acuity was reduced to 20/30 in one eye when he was examined with glasses.

[4] The pinhole test requires the use of a 1 mm aperture in a plastic disc held before the eye being tested. The improvement of visual acuity with the pinhole usually indicates a refractive disorder which can be further corrected by glasses. On the other hand, no improvement of visual acuity with the pinhole may indicate a pathological condition in the eye.

TABLE 3.—*Visual Acuity of Student with Vision Loss in One Eye (Other Eye Normal)*

VISION WITHOUT LENSES	TOTAL NUMBER OF STUDENTS	VISION CORRECTED BY LENSES									NUMBER OF STUDENTS WITHOUT LENSES AT EXAMINATION
		20/20 or 20/25	20/30	20/40	20/50	20/60	20/70	20/80	20/100	20/200	
20/30	28	6	1								21
20/40	13	3									10
20/50	3	1	1								1
20/60	0										0
20/70	2	2									0
20/80	0										0
20/100	1								1		0
20/200	4			1					2		1
Total	51	12	2	1	0	0	0	0	3	0	33

TABLE 4.—*Visual Acuity of Students with Same Loss in Both Eyes*

VISION WITHOUT LENSES	TOTAL NUMBER OF STUDENTS	VISION CORRECTED BY LENSES									NUMBER OF STUDENTS WITH LENSES AT EXAMINATION
		20/20 or 20/25	20/30	20/40	20/50	20/60	20/70	20/80	20/100	20/200	
20/30	11	1									10
20/40	11	4									7
20/50	1	1									0
20/60	0										0
20/70	8	4	1	1							2
20/80	0										0
20/100	10	5	1	2			1				1
20/200	6	2	2	1	1						0
Total	47	17	4	4	1	0	1	0	0	0	20

corrective lenses and 70 students did not have lenses at time of the examination.

It can be seen that approximately half of the students with visual defects have a corrected visual acuity of 20/25 or 20/20. Of the 70 students who did not have lenses, 53 were new cases (see Table 8) which were not classified as to type of visual acuity defect because refractions were not done during the survey. The 53 new cases had 20/30 visual acuity or worse in one or both eyes. Eight were known to the BSC but had not yet acquired glasses. Nine had forgotten, lost, or broken their glasses.

All of the 146 visual acuity defects were classified as Health and Adjustment Handicaps, as follows:

TABLE 6.—*Status of Defects Identified*

Correctable	92
Partially Correctable	4
Not Correctable	1
Partially Corrected	5
Corrected	44
Total number of students	146

The 92 students with visual defects that were judged "correctable" by means of pinhole testing were those with or without glasses whose vision was improved by means of the pinhole testing. The "partially correctable" group included those students without glasses with partial amblyopia, with some improvement in visual acuity by pinhole testing. Only one student was judged as "not correctable;" he had only light perception as a result of optic atrophy from previous trauma. The "partially corrected" group included those students with less than 20/30 vision with glasses, but who showed no improvement in visual acuity with pinhole testing. The "corrected" group included all students with glasses who had corrected visual acuity of 20/25 or better.

Relationship to Demographic Data

A statistically significant relationship between ethnic origin and the presence or absence of certain adverse visual conditions was discovered. An analysis is given in Table 7 together with the type of refractive error.

The ethnic groups are listed according to the percentage of students in each group with visual defects. The students of Chinese origin revealed significantly more visual defects than any of the other ethnic groups. The Part-Hawaiian

TABLE 5.—*Visual Acuity of Students with a Different Loss in Each Eye*

VISUAL ACUITY OF BETTER EYE WITHOUT LENSES	TOTAL NUMBER OF STUDENTS	BOTH EYES CORRECTED TO 20/20 OR 20/25	ONE EYE CORRECTED TO 20/20 OR 20/25	NEITHER EYE CORRECTED TO 20/20 OR 20/25	STUDENTS WITHOUT LENSES AT EXAMINATION
20/30	15	3	1	1	10
20/40	17	7	3	2	5
20/50	4	0	2	1	1
20/60	0	0	0	0	0
20/70	8	3	2	2	1
20/80	0	0	0	0	0
20/100	4	2	1	1	0
20/200	0	0	0	0	0
Total	48	15	9	7	17

TABLE 7.—*Ethnic Origin, Visual Acuity Defects and Type of Refractive Error*

ETHNIC ORIGIN	NUMBER OF STUDENTS IN TOTAL SAMPLE OF 1,064	NUMBER OF STUDENTS WITH VISUAL DEFECTS	PER CENT OF ETHNIC GROUP WITH VISUAL DEFECTS	NUMBER OF STUDENTS WITH REFRACTIVE ERRORS	TYPE OF REFRACTIVE ERROR						
					Myopia	*Simple Myopic Astigmatism*	*Compound Myopic Astigmatism*	*Mixed Astigmatism*	*Hyperopia*	*Simple Hyperopic Astigmatism*	*Compound Hyperopic Astigmatism*
Chinese	85	27	31.8	11	4		5		1		1
Japanese	359	57	16.2	34	17	2	12	1			2
Puerto Rican	27	4	14.8	3	1		1				1
Caucasian	199	29	14.6	18	7		6		2		3
Spanish											
Mexican											
Portuguese											
Filipino	98	12	12.1	3	2	1					
Other	27	3	11.1	2				1		1	
Negro											
Guamanian											
Korean	17	1	5.9	0							
Part-Hawaiian	225	12	5.3	5			2	1	1	1	
Hawaiian	6	0	0.0	0							
Unknown	21	1	4.8	0							
Total	1,064	146	13.8	76	31	3	26	3	4	2	7

students had significantly fewer visual defects than any other ethnic group. These differences are significant at the .01 level of confidence.

These data suggest that a majority of the refractive errors found in the Oriental racial groups were in the myopic category; namely, myopia, and simple and compound myopic astigmatism. On the other hand, those of Caucasian extraction showed more variability throughout the various types of refractive errors. The tendency for the Oriental child to be on the myopic side when a refractive error is present is in agreement with other studies and reports covering this subject.[6,7]

In line with the general objectives of the total survey, particular effort was made to learn the extent to which visual acuity defects were known at home and at school. School records were carefully reviewed. Individual follow-up interviews with parents were made by the team social worker (Mrs. Helen Hong). Table 8 is an analysis of this information.

TABLE 8

Analysis of 53 New Cases with Visual Acuity Defects

31—Not known to school[8]
- 29—Not known to parents
- 2—Known to parents
  - 1—No action
  - 1—No action on doctor's advice

15—Known to school[9]
- 13—Not reported to parents[10]
- 2—Reported to parents
  - 2—No action

7—No previous school record[11]
- 6—Not known to parents
- 1—Known to parents
  - 1—No action on doctor's advice

Color Blindness

All students were screened by means of the American Optical HRR Pseudoisochromatic Color Plates by the BSC worker. Students who failed in this screening phase were referred to and rechecked by the ophthalmologist.

Of the 1,064 students examined, 27 boys and 1 girl were identified as having a discernible loss of ability to discrimate colors on the AO HRR Pseudoisochromatic Color Test. The male incidence was about 2.5 per cent, and the female incidence was about 0.1 per cent. National figures for incidence of color blindness are 4 per cent for boys and 0.4 per cent for girls, as reported by Berens.[12] Tabulation of type of color defect by ethnic origin appears in Table 9.

No significant statistical differences regarding color blindness among the several ethnic groups

[5] See Preliminary Report in HAWAII MED. J. (Jan.-Feb.) 1960, for basis of ethnic classification.

[6] Duke Elder, W. S., Textbook of Ophthalmology, vol. IV, The Neurology of Vision, Mosby, St. Louis, Mo., 1949, p. 4249.

[7] Crawford, H. E., and Hamman, G. C.: Racial analysis of ocular defects in the schools of Hawaii, HAWAII MED. J. 9:90-93 (Nov.-Dec.) 1949.

[8] Normal vision on one or more previous vision tests per cumulative Health Record.

[9] Some visual loss recorded on one or more previous vision tests.

[10] This group includes students with 20/30 vision, identified in lower grades but having no eye symptoms. Ordinarily such children are not reported to parents in conformity with Bureau of Sight Conservation policy.

[11] Cumulative Health Record does not show previous testing.

[12] Berens, C., *et al.*: The Eye And Its Diseases, Saunders, New York, 1949, p. 198.

TABLE 9.—*Ethnic Origin and Color Defects by Class*

RACE	TOTAL	RED-GREEN DEFECT			BLUE-YELLOW DEFECT		
		Unclassified R-G	*Protan*	*Duetan*	*Unclassified B-Y*	*Tritan*	*Tetratan*
Chinese	2	1	1				
Japanese	9	2	4	3			
Puerto Rican	0						
Caucasian	10	4	4	2			
Filipino	1	1					
Other	2		2				
Korean	0						
Part-Hawaiian	4		1	2			1
Hawaiian	0						
Unknown	0						
Portuguese	0						
Total	28	8	12	7	0	0	1

were demonstrated in relation to proportions of these ethnic groups in the community. The single female in this series was a Japanese girl with an unclassified red-green color defect, which is a relatively mild defect. In agreement with national statistics, a majority of the color defects were in the red-green portions of the test. Only one student demonstrated difficulty in color discrimination in the blue-yellow range.

Ophthalmological Conditions

All students were given an ophthalmological examination after visual acuity and color screening testing. This examination included: an external examination; test of tactile tensions; pupillary light reactions; motility tests including ductions and versions and the cover test; and a funduscopic examination. Conditions such as congenital, post traumatic, inflammatory, eye muscular imbalances, disease conditions and the like were listed under "Ophthalmological Conditions."

A total of 27 students (16 boys and 11 girls) were found to have one or more ophthalmological defects. Twenty-four of the 27 students had only one defect. Of the remaining three, two were found to have two ophthalmological conditions each as follows:

(1) Eyelid—scar of left eyelid and fine nystagmus on lateral gaze (both eyes).
(2) Eyelid—mild dermatitis both eyelids and motility (exophoria).

One student had three ophthalmological conditions as follows: Scar of left eyelid; optic nerve atrophy of left eye; and left constant exotropia.

The various ophthalmological conditions are listed by anatomical location in Table 10.

Further elaboration of the categories in Table 10 is as follows: Two students had styes; two students, blepharitis; and one student a surgically repaired ptosis. Three students demonstrated a mild conjunctivitis. The one optic nerve condition was observed in a student with a post-traumatic optic atrophy. Under the heading of "Motility," one student revealed a left lateral rectus palsy in the left eye. Nineteen students showed heterophorias with convergence weakness, and heterotropias of varying degrees. One student with a fine, jerky, irregular nystagmus on lateral gaze and another student with amblyopia *ex anopsia* were placed in the last or "other" heading.

Table 11 gives an analysis of the 19 students with heterophorias with convergence weakness, and heterotropias.

TABLE 10.—*Number of Ophthalmological Conditions by Anatomical Location*

ANATOMICAL LOCATION	RIGHT EYE	LEFT EYE	BOTH EYES	TOTAL NUMBER DEFECTS
Eyelid—adnexae		4	1	5
Conjunctiva	1	1	1	3
Cornea				0
Anterior chamber				0
Iris-pupil reflex				0
Lens				0
Retina				0
Vitreous				0
Optic nerve		1		1
Motility		1	19	20
Other			2	2
Total	1	7	23	31

TABLE 11.—*Motility Disturbances*

A. Convergence weakness with remote near point of convergence and exotropia	3
B. Exophoria with remote near point of convergence	3
C. Esotropia	3
1—Partially accommodative	1
2—Constant with amblyopia	1
3—Constant with hypertropia (Previous squint surgery)	1
D. Exotropia	10
1—Alternating exotropia with equal vision	2
2—Inconstant exotropia	5
3—Constant unilateral exotropia	3
Total motility disturbances	19

Ophthalmological conditions of minor clinical importance such as scars and other findings producing no clinical symptoms were listed as "Not Remarkable." Conditions requiring further diagnostic work-up in addition to methods used in this Survey were listed under "Incomplete Diagnosis." Minor inflammatory and benign surgical conditions were listed as "Correctable"; conditions such as optic atrophy and amblyopia as "Potential Handicap" and "Not Correctable"; and all heterophorias with normal convergence measurements were listed as "Not Remarkable." Heterophorias associated with convergence weakness, and heterotropias, horizontal or vertical, were placed in the "Health and Adjustment Handicap" and "Partially Correctable" categories. Neurological conditions such as optic atrophy and nystagmus were listed as "Not Correctable."

Table 12, which describes status and correctability of these ophthalmological conditions, should be read thus: four students had health and adjustment handicaps which were considered as correctable; two students had potential handicaps which were considered partially correctable, and so forth.

The key to Table 12 is as follows:

Correctable:	(a)	Students with convergence weakness.
	(b)	Students with styes and conjunctivitis.
Partially Correctable:	(c)	Student with left lateral rectus palsy.
	(d)	Students with heterophorias.
	(e)	Students with heterotropias.
Not Correctable:	(f)	Student with nystagmus.
	(g)	Student with optic atrophy.
Partially Corrected:	(h)	Student with ptosis—previously repaired.

TABLE 12.—*Status and Correctability of Ophthalmological Conditions*

	STATUS					
SEVERITY	*Correctable*	*Partially Correctable*	*Not Correctable*	*Partially Corrected*	*Corrected*	TOTAL
Incompletely diagnosed		1(c)	1(f)			2
Health & Adj. Handicap	4(a)	12(d)	1(g)	1(h)		18
Potential Handicap		2(e)				2
Acute Condition	5(b)					5
Total	9	15	2	1		27

Summary and Conclusions

Nineteen per cent of the sample of 1,064 students had eye defects as manifested by visual acuity loss, color blindness or ophthalmological conditions:

Fourteen per cent, or 146 students, had visual acuity defects of which 52 per cent were corrected by glasses. Of the remaining 48 per cent, or 70 students, who did not have glasses, 53 were new cases; eight were identified by the Bureau of Sight Conservation but had not yet acquired glasses; and nine had forgotten, lost, or broken their glasses.

Forty-four of the 76 having glasses were corrected to 20/25 or better; thirty-two with glasses had visual acuities of 20/30 or worse.

Significant relationships were found between certain eye conditions and ethnic origin. Further studies with larger groups of students are indicated with regard to the etiology and distribution of visual acuity defects as related to ethnic origin.

Approximately 2.6 per cent, or 28 students revealed some degree of color blindness. Out of this group one girl revealed a mild unclassified red-green color defect. This would seem to have implications for program planning for eye testing in school health programs and especially in vocational counseling.

Twenty-seven students (2.5 per cent) had ophthalmological conditions.

The frequency of various eye conditions correlates well with findings of previous local and national studies.

Visual defects were found to be corrected more often than any other type of physical defect as identified in this School Health Survey.

Summario in Interlingua

Esseva trovate que 19 pro cento de un selection representative de scholares del quinte grado in le insula Oahu del stato de Hawai habeva defectos ocular del un o del altere genere. Cento quarante sex del scholares (i.e. 14 pro cento del selection) habeva defectos del acuitate visual (20/30 o pejor) sin berillos. In 44 del 146 le acuitate visual habeva essite corrigite per berillos a 20/25 o melior. Septanta non habeva berillos. Cinquanta-un habeva acuitate visual de 20/50 o minus. In 135 del 146 casos de defective acuitate visual, le defectos esseva considerate como corrigibile. Subjectos chinese habeva significativemente plus numerose defectos visual que le representantes de altere gruppos ethnic. In chineses de descendentia partialmente hawaian le situation esseva significativemente melior. Myopia esseva le defecto le plus commun inter le orientales. Le discrimination de colores esseva defective in 27 pueros e un puera Isot es un incidentia de 2,5 e 0,1 pro cento respectivemente.

Department of Health, State of Hawaii (Dr. Edgar).

Basic investigative work by a plantation physician shows that hyperuricemia is very common in Filipino men

Hyperuricemia in Filipinos

NICHOLAS STEUERMANN, M.D., Olaa, and AEME H. FARIAS, M.S., Hilo

ELEVATED VALUES of serum uric acid are found in a variety of conditions, such as kidney disease, polycythemia vera, leukemia, myeloma, toxemia of pregnancy, and rheumatoid arthritis. In only one disease, however, is an elevated serum uric acid essential, namely in gout.



DR. STEUERMANN

Goldthwait[1] states that various authors found serum uric acid values greater than 6 mgm per 100 ml in the general population. He and his associates found in a study of the Robert Breck Brigham Hospital's records 225 patients whose serum uric acid values were greater than 6 mgm per ml. Only 104 of these had gout.

Talbott[2] states that: "The malady is believed to be widely distributed throughout the world, although documentary evidence in support of this statement is lacking."

Finn[3] made a study of gout occurring among South African Indians, without being able to draw any conclusions whether gout is more prevalent in South African Indians than in the other races in South Africa.

In the voluminous literature on gout I have found but few references to gout in Filipinos. Mackler[4] in 1953 and Manahan[5] in 1954 reported an extremely low incidence of gout in Filipinos in the United States and the Philippines, respectively. In Berk's[6] series of cases of gout recorded at The Queen's Hospital in Honolulu, only one out of 74 was a Filipino. Kuzell[7] in 1955 analyzed 520 gouty patients and reported only four of them to be Filipinos.

Fisher,[8] on the other hand, found 32 cases of gout among 100 consecutive Filipino men admitted to The Queen's Hospital Outpatient Department during the last few months of 1957. Moreover, fully half of these 100 patients had serum uric acid values greater than 6 mgm per 100 ml.

The following facts tend to support Fisher's findings in regard to the high incidence of gout among the Filipino population in Hawaii:

Between the years of 1952-1958, 29 persons were treated for one or more attacks of gout at the Olaa Sugar Company Dispensary. All were Filipinos, representing 11.15 per cent of the total Filipino working force of Olaa Sugar Company. During the above years no other person belonging to another race (Chinese, Caucasian, Japanese, Korean, Portuguese, Puerto Rican) was seen for gouty arthritis.

The United States Life Insurance Company reported[9] that between December 1, 1956, and March 31, 1958, 24 claims were paid to physicians in Hawaii for the treatment of gout. Of these 24, all but four were claims submitted for Filipinos.

The present study was undertaken because I wanted to find out whether the serum uric acid content of our Filipino population is higher than that found in the general population as reported in the medical literature.

Method

Blood samples were drawn from 428 Filipino men, women, and children over 13 years of age. All blood samples were drawn in the early morning hours in fasting state, either at the Olaa Sugar Company Dispensary or in the fields. Before the blood samples were taken, answers to the following questions were recorded:

1. Name, birthdate, sex, birthplace (province) in the Philippines.
2. When did you first suffer from gout or pains in the joints, if ever?
3. Which joint is usually painful when you get these attacks?
4. Did your father, grandfather, or other male relatives ever suffer from joint pains?

Received for publication June 15, 1960.

This study was made possible by grants from the ILWU Local 142, McInerny Foundation, and the United States Life Insurance Company.

[1] Goldthwait, J. C., Butler, C. F., and Stillman, J. S.: The diagnosis of gout, New England J. Med. 259:1095-1099 (Dec.) 1958.

[2] Talbott, J. H.: Gout, Grunes & Stratton, New York, 1957.

[3] Finn, N.: Gouty diathesis with special reference to Indians in South Africa, South African M. J. 23:276 (Apr.) 1949.

[4] Mackler, H.: Gout in Filipinos, J. Am. M. Woman's A. 8:15 (Jan.) 1953.

[5] Manahan, L.: Is gout found in the Philippines? Acta Me. Phil. 10:477 (Feb.-Mar.) 1954.

[6] Berk, M. E.: Gout, report of an unusual case in a young man, Am. J. Med. Sc. 215:290-295 (Mar.) 1948.

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[8] Fisher, H. W.: The diseases of Filipino men, HAWAII MED. J. 18:252-254 (Jan.-Feb.) 1959.

[9] Personal communication from Mr. Wm. G. May, U. S. Life Ins. Co., November 1958.

FAMILY NO.	RELATIONSHIP	AGE	SERUM URIC ACID mgm %
4.	Father	65	5.3
	Mother	64	4.7
	Son	46	6.6
	Daughter	22	4.7
	Son-in-law	52	6.0
	Grandson	21	6.2
6.	Father	58	6.0
	Mother	48	4.8
	Son	17	9.1
	Son	12	6.6
	Father's brother	39	6.6
	Son	10	4.8
	Mother's brother	52	6.6
7.	Father	66	6.4
	Mother	64	4.8
	Son	43	9.1
	Son	30	7.2
	Son	27	5.1
	Son	17	7.0
	Daughter	34	4.9
11.	Father	58	6.5
	Mother	58	6.9
	Son	32	7.0
	Daughter	26	3.9
	Daughter	13	7.3
	Granddaughter	13	3.5
	Father's brother	62	5.7
	Brother's daughter	30	4.2
43.	Father	59	6.9
	Mother	41	4.1
	Son	17	5.3
	Son	15	5.6
	Daughter	21	4.0
	Mother's brother	32	5.9
	Mother's nephew	17	6.6
	Mother's nephew	15	6.8
47.	Father	52	8.2
	Mother	41	5.0
	Son	17	6.1
	Daughter	15	5.0
	Daughter	14	6.5
	Daughter	18	4.7
	Daughter	23	4.7
	Daughter's husband	37	5.2
	Daughter's son	2	5.7
	Daughter's son	4	4.4
	Daughter's daughter	1	1.6
59.	Father	50	3.6
	Mother	37	5.3
	Son	16	7.8
	Father's brother	30	7.3
	Mother's brother	41	6.8
	Daughter of above	18	6.6
	Daughter of above	20	6.4

5. Does any member of your family suffer from kidney disease?
6. Do you eat meat daily? If so, how often?
7. Do you eat fish daily? If so, how often?
8. Do you eat shellfish? If so, how often?
9. Do you use bagong sauce daily? If so, how often?
10. Do you eat entrails?
11. Do you eat raw meat? If so, how much, how often, and what do you eat?
12. Do you drink alcoholic beverages? If so, how much and what do you drink?

The subjects were instructed not to consume coffee, tea, cocoa, chocolate, or alcoholic beverages the night before the blood samples were drawn. None of them were on any medication and it was made certain that none of them were taking analgesics or any known uricosuric agents.

Caraway's method[10] was used for the determination of uric acid in the serum. Following Talbott's recommendations, all our uric acid determinations were done by the same technician, who is the junior author of this study. The reagents were freshly prepared and the determinations were done within two to four hours from the time the blood samples were drawn.

It was found that there is a difference between the two determinations (colorimetric vs. spectrophotometric) and the following quotation from Dr. Seegmiller's letter[11] gives the reason for this difference: "Our values run slightly higher than the colorimetric values you obtained. We have noted a similar effect of about the same degree in comparing our values with those obtained by our clinical-chemistry department here at N.I.H. We attribute this to the slight loss of uric acid resulting from protein precipitation procedures that are required for the colorimetric determination."

Results

Our data were submitted to the National Institute of Arthritis and Metabolic Diseases, and through the courtesy of Dr. Seegmiller were analyzed by Dr. John Z. Hearon of the Mathematics Research Panel of the National Institute of Arthritis and Metabolic Diseases. The summary of Dr. Hearon's analysis follows:[12]

1. The mean serum acid values in male Filipinos range from a low of 5.50 mgm % in age groups 13 to 14 to 7.20 mgm % in age groups 66 to 70.
2. The mean serum uric acid values in the pooled male Caucasian and Japanese group were 5.207 mgm %.
3. The mean serum uric acid values in female Filipinos ranged from a low of 4.18 mgm % in age group 31 to 35 to a high of 5.22 mgm % in age group 13 to 14!
4. The mean serum uric acid value in a female Cau-

[10] Caraway, W. T.: Determination of uric acid in serum, Am. J. Clin. Path. 25:840-845 (July) 1955.
[11] Personal communication from Dr. J. E. Seegmiller, National Institute of Arthritis and Metabolic Diseases, August 1959.
[12] Hearon, F. Z.: Analysis of data, in senior author's file.

casian population at large (utilizing Hague and Harvald data)[13] is 3.957 mgm %.

5. The mean serum uric acid value in a male Caucasian population at large (utilizing Hague and Harvald data) is 5.045 mgm %.

Total number of serum uric acid determinations in Filipinos: 428. Number of females: 94. Number of males: 334.

Mean serum uric acid value in females: 4.60 mgm per cent. Mean serum acid value in males: 6.23 mgm per cent. Range of serum uric acid values in females: 1.6 to 7.3 mgm per cent. Range of serum uric acid values in males: 2.2 to 10.1 mgm per cent.

Of the 428 Filipinos tested, 209 belong to 59 families, the rest (219) are single males. The number of members in these 59 families range from two to eleven individuals. Out of these 59 families there are seven large families who best illustrate the role of inheritance in hyperuricemia.

Discussion

The present study endeavors to prove that the Filipinos (at least those who live in the district of Puna, Island of Hawaii) are hyperuricemic. They have a higher level of serum uric acid than the rest of the population living in the same district (Caucasians, Japanese, Chinese, Korean, Portuguese, and Puerto Rican).

Some of our subjects (those over 40) were born in the Philippine Islands, the others in Hawaii. Their dietary habits do not differ from those of the other races. Our questionnaires revealed the surprising fact that the Filipinos in this part of the Island eat less meat, fish, or shell fish, than it was thought. Their diet consists mainly of rice, fruits, and great amounts of vegetables. Clearly, then, one cannot attribute their hyperuricemia to a high-protein diet. Furthermore, the hyperuricemia found in school-age children of both sexes similarly cannot be explained on the basis of their diet, since they all go to the same schools as the children of other races, where they all eat the same food.

A number of families were found in whose members high serum uric acid values are present without manifest evidence of gout. Unfortunately, we were not able to study a larger number of families, nevertheless these results tend to substantiate the thesis of other investigators,[14] who believe that hyperuricemia is inherited and is transmitted either as a Mendelian dominant or as a cumulative gene action.[15]

[13] Hague, M., and Harvald, B.: Heredity in gout and hyperuricemia, Acta Med. Scand. 152, Fasc. IV, 247-257 (Oct.-Nov.) 1955.

[14] Schlottbauer, C. F., Cotterman, C. W., Freyberg, R. H.: The genetics of gout and hyperuricemia; analysis of 19 families, J. Clin. Inv. 27:749 (Nov.) 1948.

[15] Schlottbauer, C. F., and Freyberg, R. H.: A study of hereditary nature of gout; a report of two families, Ann. Int. Med. 16:46 (Jan.) 1942. Atecher, *et al.*[16] Stetten.[17]

Finally, it seems from our study that there are certain differences in serum uric acid values of Filipinos who were born in the various provinces of the Philippine Islands. Without trying to draw any conclusions (because of the limited number of our subjects) we found that those who were born in the Ilocos Norte province had higher serum uric acid values than those who were born in the other provinces.

This study is quite rudimentary and does not try to prove that the Filipinos as a race (if there is such a thing as "race") are hyperuricemic. We did find, however, that in Hawaii at least, they suffer more from gout than the other races and that in our district on the Island of Hawaii the Filipinos have higher serum uric acid values than the rest of the population. Since this study was completed, in August of 1959, Drs. Decker, Lane, and Reynolds, of Seattle, tested fasting blood samples from 113 Filipinos employed in the Alaskan salmon packing industry and found serum uric acid values of 6.3 mgm per cent in Filipinos, in contrast to 5.0 mgm per cent in Caucasians.

Summary

Blood samples were drawn from 428 apparently healthy Filipinos and from 75 apparently healthy controls of various races. The blood samples were drawn in the early morning hours while the individuals were in fasting state, and the serum uric acid contents were determined by the Caraway colorimetric method. A statistically significant elevation of serum uric acid values in Filipinos was found, which would warrant further study along the same line in the Philippine Islands.

Summario in Interlingua

Specimens de sanguine ab 420 philippinos residente in un plantage de sucro de Hawai esseva analysate pro lor contento de acido uric e comparate (in le caso del masculos) con specimens de controlo ab non-philippinos in le area. Le nivellos del acido uric del sanguine variava inter le valor medie de 5,5 mg per 100 ml in le gruppo de etates de inter 2 e 14 annos e le valor medie de 7,2 mg per 100 ml in le gruppo de etates de inter 66 e 70 annos, a comparar con 5,207 mg per 100 ml in le combinate specimens de controlo ab subjectos caucasian e japonese. Femininas philippin monstrava variationes inter le valor medie de 4,18 in le gruppo de etates de inter 31 e 35 a 5,22 in le gruppo de etates de inter 13 e 14. Le differentias non poteva esser relationate con habitudes dietari.

[16] Atecher, R. M., Hersh, A. H., and Solomon, W. M.: The heredity of gout and its relationship to familial hyperuricemia, Ann. Int. Med. 31:595 (Oct.) 1949.

[17] Stetten, De. W., Jr.: Familial aspects of gout, Proc. 7th Int. Congress of rheumatic Dis., Philadelphia, Saunders, 1952.

There is much more to the lowly platelet than met your eye when you used to look at smears. You'll understand the clotting mechanism much better if you read this interesting story.

Present Day Concept of the Role of Platelets in Hemostasis

T. F. FUJIWARA, M.D., Honolulu

THAT THE PLATELETS serve hemostasis by initiating blood coagulation has been taken for granted during the past seventy-five years. New knowledge regarding the origin and function of these minute bodies in recent years has helped dispel some of the mysteries of hemostatic mechanisms.

Platelet Production and Delivery

Observations of living marrow tissue in an intact animal by Kinoshita revealed mitotic divisions of the megakaryoblast up to the four-cell stage. Beyond this, there was mitotic division of the nuclei, without cellular division, until the thirty-two-nucleus mature megakaryocyte was produced. This process was estimated to require approximately five days. Some of the two-nucleus megakaryocytes were seen to escape into the circulation, presumably to be trapped in the lungs, and there reach maturation and produce platelets.

After the thirty-two-nucleus stage was reached, granules accumulated in the cytoplasm, which exhibited increasing pseudopodic activity, resulting in shearing off of cytoplasmic fragments, representing platelets. These, in turn, were swept into the blood circulation. Pseudopodic activity of the mature megakaryocytes had been observed in marrow tissue cultures. Contrary to past belief, no pseudopodal extrusions through the endothelial wall occurred.

Under normal conditions, the life span of the platelet has been estimated to be around ten days and approximately 10 per cent are replaced daily. Their production is believed to be regulated by an unidentified plasma factor, presumed to be hormonal in nature. Apparently, no platelet reserve or pool exists in the body, since their removal during exchange transfusions occurs in an exponential fashion. They are also antigenic, and can produce antibodies after repeated transfusions.

Physiology of Platelet Microcirculation

Direct observations of the blood circulation in mammals showed the leucocytes traveling along the periphery of the blood stream. When the vessel wall was mechanically irritated or injured, the leucocytes were seen to adhere to the site of injury, and almost simultaneously, platelets accumulated to form a granular mass at that point. If there was no break in the endothelium, the platelet mass was washed away. In the event of perforation of the vessel wall and extravasation of blood, a platelet plug was rapidly built up, virtually capping the rent on the outside of the vessel wall with a large aggregation of platelets. Although noticeably delayed in capillary hemorrhages, there was also an immediate vasoconstriction both proximal and distal to the site of injury.

The foregoing phenomenon, resulting from vascular injury, represents the initial hemostatic

mechanism in hemorrhage. It occurs independently of blood coagulation, which follows a short time later, and requires a minimum of 10,000 normal platelets per milliliter of blood. Abnormality of this function is reflected by the bleeding time.



Bauer

DR. FUJIWARA

The remarkable ability of the platelets to adhere to the endothelial surface around the injured site is still a mystery, which may be explained only hypothetically. One plausible theory is that opsonin, which can cause adherence of the platelets to the endothelial wall, is liberated by the injured tissue and leucocytes. This is further enhanced by minute amounts of thrombin, initially generated by the extrinsic coagulation mechanism.

Viscous Metamorphosis of Platelets

The aggregation of platelets during hemostasis initiates a chain of physico-chemical reactions, which have been designated as viscous metamorphosis of platelets. The normal circulating platelets are disc-shaped with a centrally situated granulomere. They retain their individuality, until generation of minute amounts of thrombin causes the adherent platelets to become fused.

This is followed by fragmentation and eccentric displacement of the granulomere and dendritic extensions of the hyalomere, which intermesh to form a single, sticky mass of platelets, capping the ruptured vessel wall. Fibrin, formed by the interaction of the intrinsic clotting factors, is then deposited within the meshes of the dendritic extensions. Actual contraction of these dendritic fibers, brought about by enzymatic reactions within the metabolically active platelets, constitutes clot retraction.

The initial adherence of the platelets to the endothelial wall has been attributed to the localized influence of opsonin and thrombin. Bivalent cations, Mg^{++} and Ca^{++}, have been found to be especially active in promoting their clumping and fusion. Chilling and the presence of fibrin abet viscous metamorphosis by producing a morphologic change from the discoid to the spherical shape. The above mechanism must be distinguished from the agglutination of platelets from antibody reaction.

Physiological and Biochemical Mechanisms Involved in the Hemostatic Function of the Platelets

The alteration in the physical properties of the platelets brought about by the viscous metamorphosis is accompanied by increased metabolic activity of an explosive nature. There is an accelerated enzymatic reaction related to glycolysis and splitting of phosphates, resulting in the production of ATP (adenosine triphosphatides). These substances are believed to constitute the motivating principles of clot retraction. ATP has also been linked with liberation and activation of serotonin, which produces vasocontriction, believed essential for effective hemostasis. Serotonin is found stored in the platelet cytoplasm in an inactive form.

Other activities of still obscure nature, concerning amino acids, phospholipids, and dehydrogenases, have also been noted. Platelet factor 3, a lipoprotein substance necessary for activation of blood thromboplastin, has been found to be derived from the granules. The hyalomere is believed to contain platelet factor 4, a protein-carbohydrate component which interferes with heparin activity.

Comments

Hemostasis after vascular injury has been found to be dependent upon normal platelet function, independent of the intrinsic coagulation factors. The bleeding time is normal in hemorrhagic states due to defects in these factors, as well as after injections of heparin or coumarin. The serious bleeding encountered after injury in these patients is due to formation of faulty fibrin clots, which are inadequate for the permanent repair of the damaged blood vessels.

In thrombocytopenia, spontaneous bleeding occurs whenever the platelets are reduced to a level at which the endothelial integrity can no longer be maintained. The addition of stress appears to aggravate the hemorrhagic manifestations, which probably explains, in part at least, the value of steroids in the treatment of this condition.

A qualitative defect of the platelets, involving abnormal metamorphosis and possible aberration of the phosphotidyl-amine-dehydrogenase function, has been found to be the underlying difficulty in a congenital, hemorrhagic disease, designated as thrombocytoasthenia. Defective clot retraction is the only abnormality in this condition. In a similar disease, known as thrombocytopathia, the only demonstrable deficiency concerns platelet factor 3. Some patients have been known to present both defects.

Platelet function may be altered in certain pathological states, due to presence of substances in the plasma inimical to normal platelet function. Uremic plasma destroys platelet factor 3, since the platelet thromboplastin activator is not liberated after disintegration of the platelets in these patients. The macroglobulin in macroglobulinemia inhibits platelet factor 3, and the coating of the platelet by this protein interferes with dendrite formation, producing poor clot retraction.

At the present time, platelet transfusions are of limited value and may only be used in acute thrombocytopenic situations of a transient nature. Aside from the technical difficulties of separation and storage, their repeated administration may actually depress platelet regeneration, as well as nullify subsequent platelet transfusions because of antibody production.

Summario in Interlingua

Le mechanismo per le qual le plachettas servi le hemostase es non ancora completemente comprendite. Le structura interne e le histochimia del plachettas ha recentemente essite explicate plus detaliatemente. Il pare que le plachettas age initialmente per funder se in un massa collante super un ruptura in le pariete de un vaso. Illos produce extensiones dendritic con malias in que fibrina es deponite, sequite per un contraction que resulta in le formation del coagulo. Il etiam pare que illos discarga le factores plachettal 3 e 4. Illos pote esser morphologicamente o qualitativemente defective o deficiente, o lor function pote esser impedite per factores extrinsec, como in le caso de uremia o de macroglobulinemia.

1481 So. King St.

BUY

CHRISTMAS

SEALS

Inability to metabolize cystine can be fatal if it is not recognized and managed properly

Cystinosis:

An Ante-Mortem Case Presentation

JOHN R. CLARK, M.D.,* Honolulu

THIS CASE of cystinosis is presented to add one to the growing number of reported cases, to show some clinical and laboratory normal variations of the disease, and to encourage suspicion of its occurrence in clinical and hospital practice.

Case Report

A 26-month-old Negro girl was referred from another hospital for evaluation and treatment of her failure to grow.

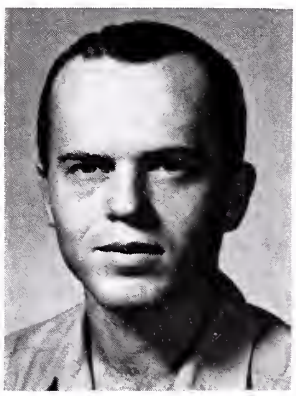
The family history for three generations, plus the prenatal and neonatal histories, were noncontributory. Birth weight was 3 kg, height 47 cm, and head circumference 33 cm. The child had a normal appetite, growth, and development until five months of age, when she began to vomit after each feeding and to lose weight from 6.8 kg down to 4.7 kg over the next eight weeks.

The initial hospitalization at age seven months was marked by spiking temperature and anorexia. She was discharged after 55 days with final diagnoses of otitis media and malnutrition, for which she was treated.

Four subsequent admissions for vomiting, anorexia, polyuria, weight loss with "dwarfism," and occasional furunculosis, required the patient's being hospitalized for most of the next 21 months for evaluation and metabolic stabilization. When discharged to her home, the patient showed a rapid decline and returned each time dehydrated, undernourished, febrile, and, the last time, dyspneic. After the second hospitalization she had polydipsia and polyuria.

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Physical examination in the present admission revealed a thin, dehydrated, doll-faced, alert and cheerful Negress. The weight of 6.9 kg and the height of 71 cm were both in the zero percentile for this age and sex. She responded well to spoken orders, and spoke with oneword exclamations or commands. She showed excellent muscle coordination despite weakness, but refused to walk unassisted. Temperature, pulse, and respiratory rate were normal; blood pressure was 60/30. Skin was loose and dry. Muscle development was poor. Her head appeared large for her body, but was otherwise normal, and she had 18 teeth. Neck and chest showed no deformities. Lungs and heart were normal. The abdomen was protuberant, with a mildly lordotic spine. The liver was palpable 2 cm below the right costal margin, and there was a slight umbilical hernia. External genitalia were normal. Extremities were within normal limits.



DR. CLARK

Studies which were done over nearly two years—including the present hospitalization—were as follows:

X-ray studies showed a normal skull, chest, and upper GI series. Long bones were demineralized at one year of age, and at 26 months showed diffuse osteoporosis with no rachitic deformities and a bone age of one

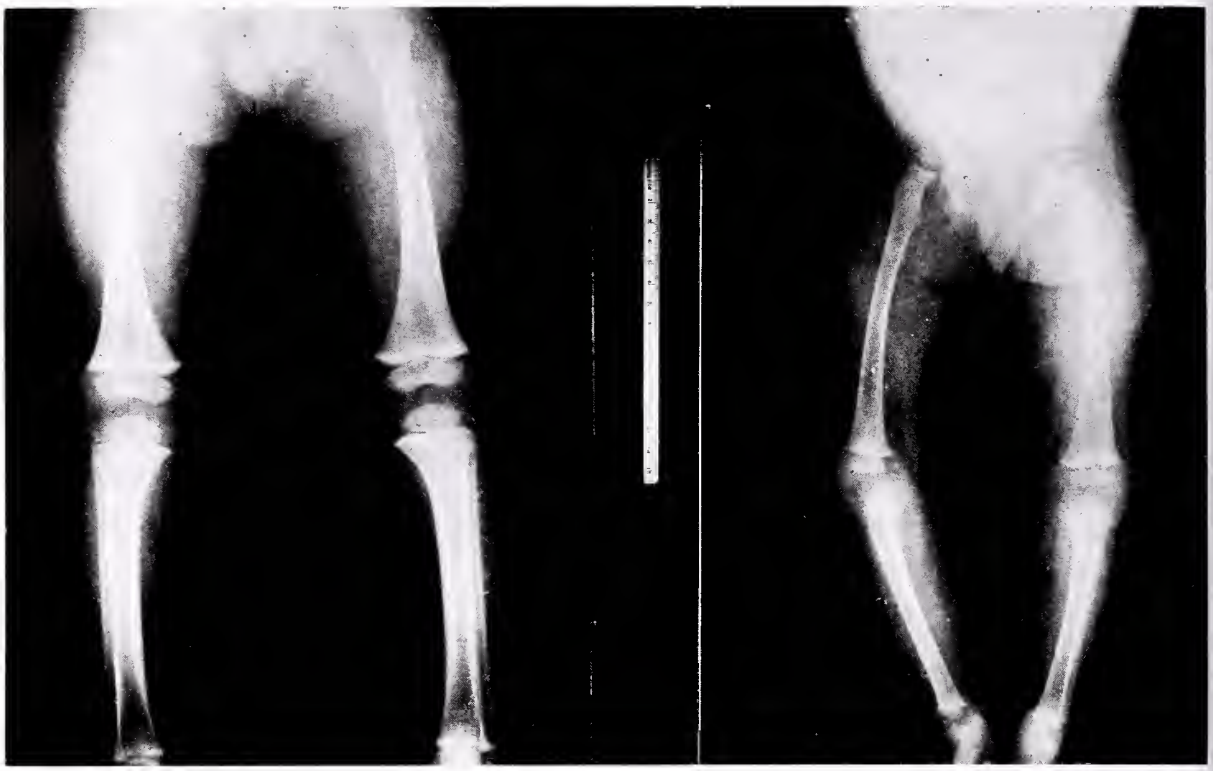


FIG. 1.—*Patient (right) compared with boy (left) her same age; the boy being in the 50 percentile for height and weight for this age and sex (13.2 Kg and 86 cm).*

year (Fig. 1). Intravenous urogram failed to show dye concentration; retrograde pyelograms were essentially normal.

Urinalyses showed trace-to-plus albuminuria, minimal glycosuria, occasional acetonuria, and few red and white blood cells. The urine had become progressively more alkaline and less concentrated over the prior hospitalizations. An Addis count showed 4.1 million leukocytes and 1.3 million erythrocytes per 12 hours. A phenolsulphonphthalein excretion test showed 10 per cent excretion in two hours. One Mosenthal and two pitressin concentration tests showed inability to concentrate over 1.006. A Sulkowitch test for calcium was negative. Urea clearance was 57 per cent of normal. Creatine was 0.4 mg%. In the present hospitalization searches for urine cystine crystals were negative, and three aminoaciduria determinations failed to show significant elevations.

Blood studies showed moderate leukocytosis and normochromic, normocytic anemia, between 7 and 10 grams per 100 ml over two years. The white count subsided over the years and was usually normal, as were the differential and the platelet counts. There was no sickling, and the reticulocytes were 0.2 and 0.8%. Serum bicarbonate showed increasing acidosis over the two years, with volumes per cent ranging from 42 to 18, initially, down to 15 to 5 in the present admission. Serum chloride, sodium, potassium, and urea nitrogen all fluctuated around normal values. Initially, serum phosphorus was elevated, and calcium was low; last determinations were normal for both.

Total proteins and A/G ratios had risen over the years as follows: 7.3 and 8.5 grams per 100 ml (total), and 5.3/2.0 and 4.4/4.1 (A/G ratios). Cholesterol was 112 mg%. Alkaline phosphatase levels were 6.0 and 4.1 Bodansky units. Cephalin flocculation was 4 plus for both 24 and 48 hours; thymol turbidity was 3.4 units, and negative for flocculation at 18 hours. Uric acid was 2.0 and creatinine was 2.1 mg%. A glucose tolerance test showed almost a straight line ascent from the fasting to the three-hour level, the five determinations being 108, 136, 128, 152, and 192 mg% respectively. The last two figures were not available in time to go on with hourly determinations to see any descent. The test was tolerated very well. In the present admission two determinations for plasma lysine showed quantities of 3.4 and 1.9 mgm/100 ml.

A fecal trypsin test was postive.

Two ophthalmologic examinations with a slit lamp microscope showed crystalline deposits behind or in both corneas.

Sternal bone marrow aspirations revealed many clumps of rectangular birefringent crystals, identified by polarized light microscopy as cystine (Fig. 2).

Over the present ten weeks' hospitalization the patient was generally in good clinical status. Several acidotic episodes were encountered, usually following some stress such as laboratory, x-ray, and urologic study. During these occasions the patient had varying fevers, low CO_2, dehydration, vomiting, and occasional tetany. Polydipsia persisted, with an average daily intake of about 2100 cc (normal for size and age: about 700 cc), and a polyuria of about 1800 cc (normal expected: about 500 cc). Her appetite constantly fluctuated from

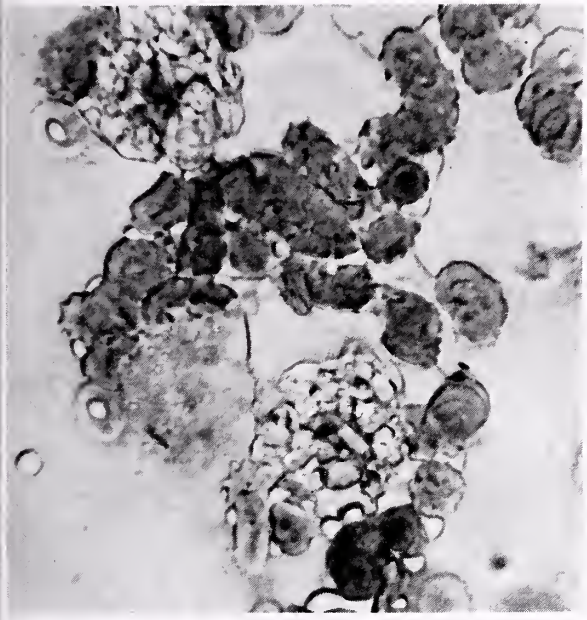


FIG. 2.—*Sternal bone marrow with cystine crystals.*



FIG. 3.—*Patient near time of discharge from hospital (September 1958).*

nibbling at everything in the full hospital diet to complete refusal of anything but clear liquids. Vomiting sporadically occurred after feeding and was not related to type of intake; the mode of vomiting ranged from projectile to simple regurgitation. She never showed photophobia. Constipation was frequent and rarely attributable to diet or therapy. The thermolability, especially after stress, was not consistent with the patient's clinical appearance, which was remarkably stable during these changes.

The patient had come to this hospital after several months of alkalizing therapy. She was maintained on 50,000 units daily of vitamin D_2, high doses of other vitamins, an average of 825 cc of a commercial oral electrolyte solution, 80 cc of sodium citrate solution, and full diet when taken (always offered before the fluids).

The patient (Fig. 3) was discharged with an improved appetite, weight of 7.5 kg, and an unexplained improvement in urine concentrating ability. She was walking alone for the first time, but otherwise had little clinical change. The mother was instructed to continue the above quantities of vitamin D_2 and sodium citrate solution and to keep the hospital informed of the patient's progress.

The patient was admitted three months later for otitis media. During this interim the patient had subsisted quite well outside the hospital, and had improved slightly over her status prior to discharge: infrequent vomiting, better appetite, and progress in walking and talking. However, her tremendous fluid exchange stayed the same, and her weight slowly decreased. Her hospital course was similar to the last hospitalization, with slightly less acidosis, better appetite, and more electrolyte stability. Confirmation of prior laboratory studies were obtained, including cystine crystals in sternal bone marrow. The patient is now being kept institutionalized for treatment and for environmental reasons.

Discussion

Among the several pediatric illnesses producing an organic aciduria, cystinosis is distinct in its ability to toxify the body with amino acid crystals. The involvement of the renal tubules renders the outcome fatal, if untreated. Whether or not cystine is the only amino acid so implicated is not certain; its relative insolubility makes cystine crystals the only proved pathogenic agent in this disease.

Diagnostic criteria include aminoaciduria, acidosis, and cystine deposits in parenchymatous organs. Clinical and laboratory features, probably as manifestations of the above triad, usually include failure of growth, rickets, hypophosphatemia, glycosuria, nephrogenic diabetes insipidus, and thermolability. Etiologically, it is presumed that the victims have a defect in sulfur-containing amino acid metabolism[1] on an enzymatic basis.[2]

Differentially one must consider any of the illnesses producing either failure to thrive or high quantities of urinary organic acids, or both. These two factors have led to considerable confusion among entities appearing under the following names: deToni-Fanconi-Debre syndrome, Lignac-Fanconi and Abderhalden-Lignac or Lignac's disease, amino acid diabetes, infantile deToni

[1] Bickel, H., *et al.*: Cystine storage disease with aminoaciduria and dwarfism, Acta Paediat. Supp. 90, 42:7-232 1952.

[2] Kretchmer, N.: Clinical conference: cystinosis, Pediatrics 19:962-966 (May) 1957.

syndrome (of which "Milkman's syndrome . . . probably represents the adult form."),[3] juvenile form of cystinuria, cystine storage disease, and the Fanconi syndrome. The latter term is the only correct synonym for cystinosis, according to Lowe.[3] Among the better-established diagnostic considerations would be rickets (the form resistant to, as well as the form deficient in, Vitamin D), celiac disease, hyperparathyroidism, hepatolenticular degeneration, and diabetes insipidus. Some clinical and laboratory highlights of this case will be discussed.

The rickets of cystinosis is not a true vitamin D deficiency rickets. In this patient there were no craniostoses and the fontanelles were closed by twenty months. While the head has enlarged since birth—it was in the 50 percentile for this age and sex—it retained an infantile shape with a prominent brow. The almost lordotic spine is not abnormal. Elbows, wrists, knees, ankles, and the ends of long bones are normal; there have been no pathologic fractures nor deformities. Abdominal protuberance, bone demineralization, elevated alkaline phosphatase, slightly low serum calcium, and occasional tetany appear to be the only rachitic findings. The patient was put on therapeutic doses of vitamin D_2 in her early hospitalizations and this therapy was continued.

Acidosis has consistently been borne out by clinical features (restlessness, hyperventilation, dry skin, vomiting), and by laboratory data (low bicarbonate, alkaluria). The occasional aciduria and episodes of tetany might have been due to a transient alkalosis, engendered by high alkaline intake and augmented by stress hyperventilation. Barring a transient alkalosis, the tetany can be explained by alkali treatment alone, or by an unusual sensitivity to normocalcemia, for the plasma calcium was never recorded lower than in the normal limits. A negative Sulkowitch test may indicate either that a calcium deficiency existed at the time, or that the kidneys were unable to excrete calcium in the urine; but the test is not absolute.

It is likely that the long-term alkalizing and vitamin D_2 this patient had can explain why hypophosphatemia has not been observed.[4] The extreme phosphate level variability has been noted by others.[7]

Most urinalyses showed glycosuria. The range was from negative to over one per cent (3 plus). It is likely that the inconsistency of a positive test is a result of the chronicity of the disease with long-term alkalinization and vitamin D_2 therapy.[10]

Hyperaminoaciduria was not observed. This is most likely due to the chronicity of the case, the prolonged alkalinization with addition of vitamin D_2, and the variability in daily excretions of amino acids, which often happens in cystinosis.[12]

The determinations of plasma lysine showed a normal value on one occasion and a slight elevation on the second. Further investigation along this line was not pursued. It is believed that the same reasons for normal plasma levels as above apply here.

It is unfortunate that few cases of this disease are studied intensively in their amino acid make-up in the initial evaluations of the cases. It is very probable that considerable light could be shed on the pathogenesis of cystinosis if amino acid metabolism was thoroughly investigated before the presenting signs and symptoms were treated.[13] The recent case of Korn in which peripheral blood cystine crystals were studied exemplifies the fruition of such research before therapy is instituted.[14]

The glucose tolerance test on one occasion was normal. A repeat test one year later showed a prolonged elevation. That an elevated curve is frequently seen in cystinosis is not remarkable;[15] that it did not return to fasting level in three hours is significant only in further demonstrating the rampant variability of the patient's blood constituents.[16]

The recessive characteristic of cystinosis cannot be demonstrated in this case. All four siblings are alive, well, and of normal growth and development, although the first three were "small for their age at one year." All deaths among the patient's few relatives were due to causes outside the metabolic system.

The polydipsia and polyuria, together with inability adequately to concentrate the urine despite pitressin stimulation, are supposedly due to a nephrogenic diabetes insipidus which is often associated with cystinosis.

Glomerular damage is shown by the abnormal Addis count. The decreased PSP excretion and

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[14] Korn, D.: Demonstration of cystine crystals in peripheral white blood cells in a patient with cystinosis, N. Eng. J. Med. 262:545 (Mar. 17) 1960.
[15] Bickel.[1] Kretchmer.[2]
[16] McCune, D. J., Mason, H. H., and Clarke, H. T.: Intractable hypophosphatemic rickets with renal glycosuria and acidosis (the Fanconi syndrome), Am. J. Dis. Child. 65:100-103 (Jan.) 1943.

urea clearance both reflect tubular damage. The alkaluria supports these findings, as do the glycosuria and albuminuria. That any kidney lesion is primarily at fault, however, remains to be shown. The nephrotoxicity of cystine and other amino acids cannot be ruled out as being the basis of these impairments.[17]

Conjunctival cystine deposits were not seen by any of the three examining ophthalmologists. Corneal mottling was easily seen with an ophthalmoscope, however, and the slit lamp microscope showed these opacities to be crystalline.

Cystine crystals in the bone marrow is a *sine qua non* of diagnosis.[1] Two determinations were attempted (tibia and ilium) before a third—and positive—specimen was obtained from the sternum. The first two specimens failed to show adequate bone marrow. The accompanying photo of these crystals shows the specimen which was diagnosed (Fig. 2). The findings by polarized light microscopy showed the typical configurations of cystine.[18]

Throughout her hospitalization the patient was titrated with sodium citrate solution (sodium citrate 10 Gm, citric acid 6 Gm, water 100 cc), and a commercial oral electrolyte solution. Due to the numerous variables in her symptoms, an accurate titration was almost impossible, and the eventual dosages were decided upon on the basis of empiric laboratory and clinical data. For the last three to five weeks of her hospitalization the patient averaged 825 cc of the commercial oral electrolyte solute daily, with 80 cc of sodium citrate solution. She was discharged with daily therapy of 100 cc of sodium citrate solution, 50,000 units of vitamin D_2, and iron and vitamin therapy.

This appears to be the first reported case of cystinosis in a Negro.

[17] Newburgh, L. H., and Marsh, P. L.: Renal injuries by amino-acids. AMA Arch. Int. Med. 36:682--711 (Nov.) 1925.
[18] Bickel.[1] Freudenberg.[19]
[19] Freudenberg, E.: Cystinosis: cystine disease (Lignac's disease) in children. In Levine, S. Z., *et al.*, Advance. Pediat. 4:265-292 1949.

Summary

Cystinosis was diagnosed in a 28-month-old Negress. The patient exhibited dwarfism, osteoporosis, glycosuria, nephrogenic diabetes insipidus, and chronic acidosis. Not seen, but postulated as having been present prior to alkali treatment, were aminoaciduria and hypophosphatemia. The pathognomonic findings of cystine in the corneas and bone marrow established the diagnosis.

A discussion of the findings was made, and an attempt was made to correlate the results with the patient's clinical status.

Summario in Interlingua

Le incapacitate de metabolisar cystina—con le resultante accumulation de illo in le tissus—es un geneticamente determinate defecto metabolic de potentialitates mortal. Illo es characterisate per amino-aciduria, acidose, depositos de cystina in varie organos, e—in varie combinationes—dysfunction crescential, rhachitis, hypophosphatemia, glycosuria, nephrogene diabete insipide, e thermolabilitate. Es reportate un caso del condition occurrente in un puera negre de duo annos de etate. Le parentes, granparentes, a quatro fraternos non pareva esser afficite per le disordine. Crystallos de cystina esseva demonstrate in le medulla ossee. Le symptomas esseva subjugate per le administration de citrato de natrium, vitamina D_2, e ferro.

Lt. (MC) USNR
Pearl Harbor Shipyard Dispensary
F.P.O. San Francisco

University of Hawaii Link

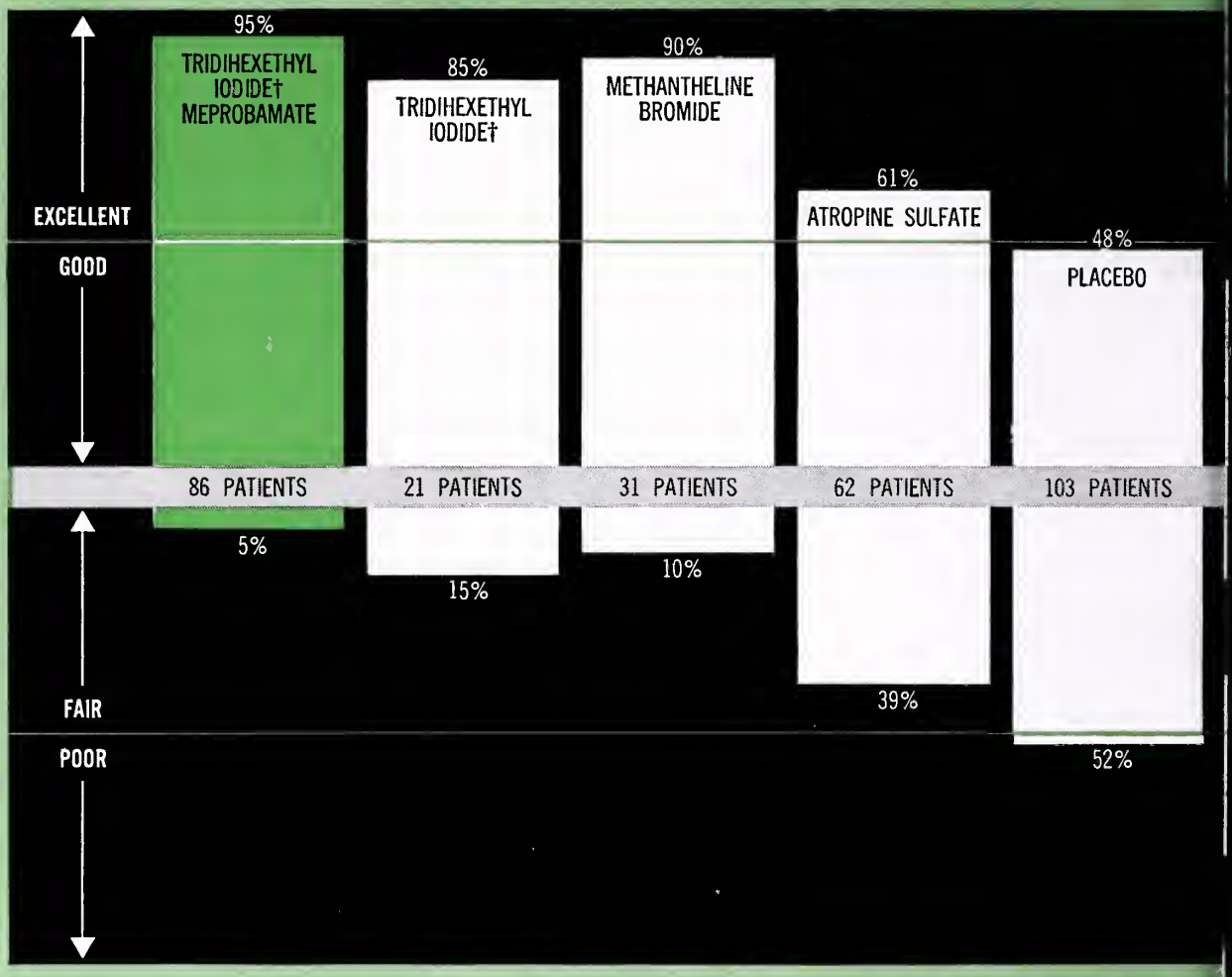
Hawaii's unique situation at the crossroads of the Pacific offers unusual educational opportunities for public health. Founder's Gate gives the signal with its inscription in the Hawaiian language, the translation of which is "Above All Nations is Humanity." Here with cultural interchange a prominent feature, where a goal of intercultural harmony is fostered, where educational and research resources are increasing, where a great East-West Cultural Center is on the horizon, where a new Institute of Health Research is in the offing, and where there is one of the best state health departments to be found anywhere, the opportunities for advancement toward our objective are unlimited. Dividends could be large.

*A World Health Picture**
IRA V. HISCOCK, SC.D.
Carnegie Visiting Professor,
University of Hawaii

* Connecticut Medicine 24:375 (June) 1960.

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STOMATITIS	1%	0%	28%	14%	0%
VISUAL DISTURBANCES	0%	0%	50%	34%	1%
URINARY RETENTION	0%	0%	18%	11%	1%
DROWSINESS	20%	0%	0%	0%	0%
COMPLICATIONS OR SURGERY					
HEMORRHAGE	0%	9%	3%	9%	10%
PERFORATION	0%	0%	0%	6%	0%
OPERATION	0%	5%	5%	14%	2%
RECURRENCES					
NONE	28%	23%	25%	17%	26%
FEWER AND MILDER	67%	62%	52%	37%	24%
SAME OR MORE	5%	15%	23%	46%	50%

twater, J. S., and Carson, J. M.: Therapeutic Principles in Management of Peptic Ulcer. Am. J. Digest. Dis. 4:1055 (Dec.) 1959.

ATHILON is now supplied as tridihexethyl chloride instead of the iodide, an advantage permitting wider use, since the latter could stort the results of certain thyroid function tests.

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The President's Page



DR. CUSHNIE

Well, the election for President is just over. Many times the question seemed to be "Which one of the candidates will do me the most good?" This apparently is a heritage of our democratic process—to blazes with the majority. I was just wondering if the doctors are included in this way of thinking. Of course they are. After all, the Congo is far away and so are Matsu and Quemoy. And there are many things closer—like "every one's wrong but us doctors" and our problems.

We are all interested in the aged: the government, the social workers, the good folk and the bad folk (the psychiatrists notwithstanding) and the children of the aged, probably some of the aged—over 65. And I must say rightly so. The Medical Association has a committee, a good one; the Governor has a committee, a good one. The big question is how to go about giving the aid. Will we just let those who have a little land and a house keep it and give them free medical care, or will we have them sell their homes and their TV sets and pay for medical care and put them into welfare cases—completely?

I feel we should see to it they get medical care by some means whereby they will not be driven to become true indigents by an arbitrary means test—or any other test. After all, I think the dignity of the individual can decide many of the problems. There are those who can buy insurance if given a policy they can afford. Others should keep what they have and be given medical aid if necessary without becoming wards of the State. After all, a new concept is necessary to give the aged medical care if they can't afford it and still keep them in dignity and usefulness as citizens in a community. Let's not make "welfare state" out of the problem, for we can certainly work the problem out. I am certain there have been tougher ones.

There are more than straws in the wind to have the Stockton Plan instituted here by the Honolulu County Medical Society. The plan simply means the doctors make the fee schedules and open them to bid by any insurance carrier, including the HMSA, who wants to carry it. Hospitals will be separate. It is a plan run by the doctors and disciplined by doctors. It seems simple. I am sure we have something, but I am also sure we have a lot of things with it which we can't see.

We have Mr. Hugh Lytle doing a job of research as to what we need and should do in a public relations basis with the people and with the legislators. The doctors employed him for the month of October. His report will be analysed and then given to the Council for it to determine where to go from here.

Aloha Week has come and gone. The aloha shirt problem and the participation in events has been observed only to a degree by the doctors. I feel if they want Aloha Week, cut it down to two or three days and stop all work and everyone go out and raise cain and make it worth something. Work and play don't seem to make for a good Aloha Week participation. Maybe it is only for the tourists, after all, to find the aloha spirit.

Edward Cushnie

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[EDITORIALS]

Our Children's Keepers

Responsibility for the prevention of preventable diseases, from smallpox to traffic accidents, has been accepted willingly by most thoughtful persons for the past century or more.

Responsibility for the prevention of dental caries—a disease now established as largely preventable by a simple, innocuous, inexpensive process known as fluoridation—is rejected by a substantial minority of citizens despite its endorsement by an overwhelming majority of medical, dental, public health, chemical and other scientific authorities and organizations.

An "Occasional Survey" in a recent issue of *The Lancet*[1] says there are two main arguments against it: compulsory medication is repugnant, and the possibility of chronic toxicity of fluorides has been insufficiently studied.

Of course compulsory medication is repugnant. Compulsory vaccination is repugnant. But fluoridation is not medication; it is the provision of a nutrient in places where its natural source (drinking water) is deficient. Medications are given in measured amounts, and they are not incorporated into the body structure. Nutrients are given *ad libitum,* and they are metabolized and incorporated into the body structure. This is the case with fluorides in drinking water.

The Lancet's review concludes with a quotation from a recent article[2] by R. A. Kehoe: "... it is inevitable that fluoride is incorporated in the chemical composition of living organisms, including the human organism. Even if it were not involved usefully in certain processes of the living organism, the certainty of its presence within the organism establishes the fact that fluoride is ... part of the internal environment of the human organism. It cannot, in this relationship, be, in itself, harmful. In appropriate concentrations it enters into specific reactions which are beneficial."

Some of the evidence gleaned from over 15 years of controlled studies of fluoridation in a score of American cities is reviewed in a current issue of the *Armed Forces Medical Journal,* in an article by Colonel Kenneth Elwell.[3] He points out in conclusion that about 42,000,000 Americans—one out of four—are drinking artificially fluoridated water. There are 3,500 such communities.

Honolulu has a far more serious and extensive dental caries problem than any comparable American community. We have fluoride in our drinking water, but the concentration is not high enough to be useful. We are already using all the practicable alternatives to fluoridation, and the results are predictably bad. We are, to paraphrase Cain, our children's keepers—and we aren't keeping them well. We are shirking our responsibility to them. Honolulu needs fluoridation, and needs it badly. What are we waiting for?

[1] Medical and biological aspects of fluoridation (Occasional Review), The Lancet 2:425 (Aug. 20) 1960.
[2] Kehoe, R. A.: Human health and modern environment, A.M.A. Arch. Industr. Health 21:306(Apr.) 1960.
[3] Elwell, K. R.: Fluoridation of water for dental public health, Armed Forces Med. J. 11:1085 (Oct.) 1960.

Utilization of Empty Tuberculosis Beds

In 1955, the Board of Trustees of Leahi Hospital announced their willingness to confer with other community agencies regarding the utilization of their surplus bed facilities. They said, among other things, that they regarded it as wasteful to use their beds for domiciliary care. They suggested that specified types of chronic illness be given the next priority after tuberculosis, as follows: (1) chronic pulmonary diseases (non-tuberculous), (2) chronic cardiovascular-renal disease, (3) leprosy complicated by other disease, (4) arthritis and rheumatism, (5) chronic neurological diseases, and (6) diabetes in aged patients. They specifically objected to the use of their beds for senile patients without remediable disease.

In August 1959 the Trustees outlined policies governing admission of indigent and medically indigent persons suffering from non-tuberculous chronic respiratory diseases. The principal requirement was that such patients must be suitable for partial or complete rehabilitation, or at least prevention of further deterioration.

Now, following a series of conferences with representatives of the Health Department, the Social Services Department, the City and County Health Department, the Hospital Council of Honolulu, and the Honolulu County Medical Society, the following tentative agreement has been reached:

1. Leahi Hospital will accept by transfer 25 non-tuberculous patients from Maluhia Hospital now, and possibly more later, when the staff has been increased to care for them.
2. Future cases will go from general hospitals to Maluhia Hospital to Leahi Hospital, so that the process can be screened by the City and County Medical Department.
3. Any acute illness occurring in such patients will be cared for at Leahi Hospital while the patient is there, if such care is "within their medical and surgical means."
4. Such patients may be returned either to Maluhia Hospital, a general hospital, or the community, at the discretion of the Leahi medical staff.

This will be, notwithstanding the proposals made over a year ago, the first use of Leahi Hospital for treatment of anything but suspected or actual tuberculosis. It is an inevitable consequence —failing destruction of the facilities by fire or disaster—of the introduction of antituberculous chemotherapy in 1947. Technological unemployment can affect hospital beds as well as working men. This is a sound and practical solution to it, which will do every person and institution concerned a lot of good, and no harm.

To Share My Substance

The debt owed by physicians to their teachers was one of the earliest responsibilities laid upon the medical profession. The Hippocratic Oath spelled it out:

> *To reckon him who taught me this Art equally dear to me as my parents; to share my substance with him, and relieve his necessities if required.*

In acknowledgment of this debt, during 1959, American physicians donated $4,355,408 to American medical schools—an average of $28 from 55,527 physicians donating to the American Medical Education Foundation, and an average of $56 from each of 55,924 physicians donating directly to their school.

In only six states—Indiana, Minnesota, Nevada, New Mexico, South Carolina and Tennessee—did the AMEF contribution exceed the direct alumni gift. In three of these—Indiana, Minnesota and Nevada—the per capita AMEF contribution was much smaller than the per capita direct gift. In New Mexico and Tennessee it was larger, and in South Carolina it was a whopping $300 per capita for AMEF and $40 per capita for direct gifts. How they missed getting an Award of Merit is difficult to see.

Hawaii's physicians gave an average of $47 each through AMEF and $52 apiece by direct donations—an average of $50 each from 300 doctors. We were outdone by 52 Alaskan doctors, who gave an average of $100 each through AMEF and $54 each by direct gifts. One of our number, however (Dr. Kiyoshi Inouye) received an Award of Merit for an outstandingly generous donation.

AMEF funds earmarked for the donor's own school are transmitted intact. AMEF funds not earmarked are divided equally—in 1959, every four-year school received $4,925 and two 2-year schools received $2,462 each.

Help keep American medicine free of government controls—give generously to your school each year, either directly or through the AMEF!

This is What's New!

"Cloud baby," in spite of his innocent name, s often the culprit in **staphylococcal disease of ıospital nurseries** and family units. Most new-- ›orn babies with staphylococci in their noses have ow rates of infectivity. The cloud baby, on the ›ther hand, is surrounded by a cloud of respiratory 'iruses often saturated with disease-producing bac- eria. He is clinically well and the cloud can only ›e detected by quantitative air sampling. (*Am. J. Dis. Child.* [Aug.] 1960.)

* * *

Radioactive iodine is just as good in the treat- nent of hyperthyroidism due to **toxic nodular goiter** as it is in toxic diffuse goiter. Of 436 pa- ients treated, 92 per cent were cured and 8 per ent made permanently myxedematous. The per- entages are exactly the same in a group of patients reated for toxic, diffuse enlargement of the thy- oid. In the nodular variety, the required dose was ıalf again as large and a second treatment re- quired slightly more often than in the diffuse type (10.3 mc vs. 7.2 mc of RAI and 2.2 treatments vs. 1.9). (*Ann. Int. Med.* [May] 1960.)

* * *

Jet pilots with abnormal EEG's crash more frequently than those with normal EEG's. Danish Air Force cadets had routine EEG's taken prior to et pilot training. The crash rate was three times ıigher in the pilots with abnormal EEG's as com- ›ared to the group with normal tracings. Because ›f these findings, all jet pilot candidates with narked EEG abnormalities are rejected without re- gard to clinical findings. (*Epilepsia* [June] 1960.)

* * *

Cooper, using the same technique* as in the surgical treatment of parkinsonism, finds that he s able to relieve the **intention tremor** of **mul- tiple sclerosis** and **cerebellar disease.** Some of he patients so treated had diminution of nystag- mus also. (*New Eng. J. Med.* [Sept. 1] 1960.)

* He blows up a small balloon in the region of the ventrolateral nucleus of the thalamus, produces a reversible lesion in this manner, and observes the conscious patient for loss of tremor. If the tremor disappears, alcohol and iophendylate mixture is injected to produce a permanent lesion.

In combined chemotherapy-surgery of cancer, **smaller dosage** of the chemotherapeutic agent may be advisable if the patient is **cachectic** or has been on **parenteral fluids** for several days prior to surgery. The toxicity of one such agent (5-fluorouracil) is potentiated in the debilitated patient. (*Arch. Surg.* [Aug.] 1960.)

* * *

Aturban, a glutaric acid derivative, is a new **antiparkinsonian** preparation. In a small series, it was found superior to other drugs in reducing tremor. Dose: 5 mg three to four times daily. (*Sem. Med. Buenos Aires* [Mar.] 1960.)

* * *

Idiopathic fibrous myocarditis may be **allergic** in nature, according to reports from Geneva. The investigator finds EKG evidence of myocardial involvement in generalized allergic reactions especially serum sickness and drug hypersensitivity with skin manifestations. Anaphylactic shock produced by horse serum caused EKG changes within a few minutes in rabbits so treated. These changes were very similar to the human abnormalities, as were the histologic changes. (*Schweiz. Med. Wschr.* [Aug.] 1960.)

* * *

Buerger's **thromboangiitis obliterans doesn't exist** either clinically or pathologically, and the concept of this as a disease entity should be dropped, is the word from Boston. The authors could find no changes in autopsy, biopsy, or amputated specimens that could not be explained by atherosclerosis, embolization, or thrombosis. (*New Eng. J. Med.* [June 6] 1960.)

* * *

Kangaroos caused **ringworm** in eight Australians between 1955 and 1959. The eight victims had acquired the little hoppers for pets. Rule: If a patient has markedly inflamed ringworm and owns a kangaroo, the causative fungus will probably turn out to be Trichophyton mentagrophytes. (*Med. J. Australia* [May] 1960.)

FRED I. GILBERT, JR., M.D.

In Memoriam--Doctors of Hawaii--XXIX

This is the twenty-ninth installment of In Memoriam—Doctors of Hawaii.

Albert Bradley Carter

Albert Bradley Carter was born in New York City, February 23, 1860, the son of a wealthy grocer.

He was educated in the New York public schools and attended the Columbia College of Physicians and Surgeons from which he received his M.D. on October 18, 1881.

After graduation Dr. Carter practiced in New York and did a lot of emergency work which often took him as ambulance surgeon to Hell's Half Acre and other rugged areas in the Bronx. On July 28, 1885, he was licensed to practice in Indiana.

In October, 1886, Dr. Carter took passage on the S.S. *"Alameda,"* headed for China. However, the trip to Honolulu so depleted his supply of clean clothes that the first problem on docking was to find somebody to do his laundry. When his clean laundry was not returned on time, his ship sailed without him. Before another ship bound for China came into port, Hawaii had worked its familiar magic, and Dr. Carter had decided to remain. He became associated with Dr. John Brodie in the practice of medicine in Honolulu. Later he moved to Waialua, where he served as government physician for the district of Koolau, which included Waialua, Koolau, Hauula, and Kaneohe. He was interested in bacteriology and had his own laboratory.

On September 24, 1887, in Honolulu the doctor married Miss Margaret Victoria Lane, sister of a former mayor, John Lane, of Honolulu. Dr. and Mrs. Carter were the parents of eight children: Thomas J., Henry C., William L., Eunice K. (Mrs. Erik Hinrichsen), Betrix K. (Mrs. David Bell), Albert B., Jr., Harriet B. (Mrs. Harriet Mairs), and Richard L. Carter.

In June, 1890, the *Advertiser* reports that Dr. and Mrs. Carter were among the guests at a grand ball given by His Majesty, King Kalakaua, in honor of the officers of the men-of-war in port, the occasion being the departure of H.B.M.S. "Champion" for British Columbia.

In October of the same year the doctor took his family to the mainland, where they lived in New York and Pennsylvania. About 1898 Dr. Carter returned to the Islands and settled permanently at Hauula. Financially independent (the 1898 Directory listed him as "capitalist"), Dr. Carter did not engage in active practice on his return, but many Hawaiians came to him for medical help, and these he treated without charge.

Dr. Carter died on March 31, 1927, in Honolulu at the age of 67.

Charles Fessenden Nichols

Charles Fessenden Nichols was born February 20, 1846, at Salem, Massachusetts, the son of Charles Saunders and Amelia Ann (Ainsworth) Nichols.

Educated in the public and private schools of Salem, he studied in Germany from 1864 to 1866. Harvard Medical School granted him his M.D. in 1870. The *National Cyclopedia of American Biography* speaks of his studies in the homeopathic school of medicine with the Drs. Wesselhoefts of Boston, but does not make it clear just when this occurred. Since he always advertised himself as a homeopathic physician, it can be concluded that his homeopathic training was obtained in the interval between his return from Germany and his entry into Harvard. Dr. Nichols interned at Massachusetts General Hospital and was House Physician at Carney Hospital. Again the timing is vague, but we can presume that his hospital experience took place between his graduation and the time he left for Hawaii to begin his practice.

It was at the invitation of Chief Justice Allen of Hawaii that Dr. Nichols accompanied him to Honolulu, arriving on the "Moses Taylor" on November 25, 1870. He was especially interested in testing the merits of the homeopathic treatment in leprosy and other diseases prevalent here and opened an office in December on the corner of Fort and Merchant streets. Dr. Nichols was successful enough to number among his patients members of the royal family and chiefs as well as foreign residents.

On April 16, 1872, he boarded the "Nebraska" to return to Boston where he became associated with his former teacher, Dr. W. P. Wesselhoeft.

On May 7, 1884, Dr. Nichols married Miss Grace Belle Houston of Boston. His second marriage took place on June 9, 1898, to Miss Anna Jenetta Van Arenberg. He was the father of a daughter, Cherry Elizabeth, and a son, Fessenden Arenberg.

Dr. Nichols became the editor of the *New England Medical Gazette* in 1874. Combining literary propensity with an interest in natural science, he contributed articles on tropical climate, ferns and Polynesian life of *Harper's Magazine, New England Magazine, Overland Monthly, Science, Popular Science Monthly,* and *Review of Reviews*. His two years in Hawaii furnished him with material for papers which "analyzed the hoodoo witchcraft of Polynesia" and studies of the religion, political status, and events in Hawaii and Polynesia.

In 1891 and 1892 he was a member of the editorial staff of *Science*. His articles on the Koch controversy were widely read. Koch claimed the prediscovery by the homeopathic school of a treatment for tuberculosis. Dr. Nichols also published a number of brochures urging caution in the use of inoculable and vaccinal serums. Following a paper in the *Review of Reviews,* March, 1895, written by the doctor upon the effects of the climate in southwestern United States on tuberculosis, the American Invalid Aid Society was organized with Dr. Nichols as one of two vice-presidents. This group sent from 20 to 100 consumptives annually to the southwest with, it is claimed, 90 per cent cures.

Before going to Germany the doctor served as curator of coins and catalogues in the Peabody Academy of Science (1860-1864) and had a valuable personal collection of coins. He also had a unique collection of land shells made during his stay in Hawaii.

Dr. Nichols died at his home in West Roxbury, Boston, on April 5, 1915, at the age of 69.

He was a member of the American Institution of Homeopathy, the Massachusetts, Boston, and International Homeopathic Medical societies, Organon Society, New York Society for Humane Medical Research (vice-president 1908-1909), American Anti-Vivisection Society, and an adopted member of the Hawaiian Society of Mission Children.

Book Reviews

Pardon My Sneeze

By Milton Millman, M.D., F.A.C.A., 215 pp., $4.00, Frye & Smith, Ltd., 1960.

Pardon My Sneeze is written primarily for the allergic patients and their caretakers. It presents fundamental information on the various aspects of allergy. The third phase of the book deals with the avoidance and elimination of the allergens. A large part is given to food manipulations and food recipes. Those invididuals involved with allergies, after reading this book, should acquire a better understanding of the allergy and surely should benefit from it clinically.

CLARENCE Y. SUGIHARA, M.D.

Principles of Orthopedic Surgery

By Paul C. Colonna, M.D., 799 pp., $22.00, Little, Brown, & Company, 1960.

This is a good book, as the title says, for basic principles of orthopedics. In this edition Dr. Colonna has added a little over 100 pages. Most of these were added in the first half. He went into the causes and treatment of back pain more deeply.

I compared this edition with the 1950 edition. He does add later references but the changes are not great enough so that I would want to have this edition since I already have the 1950 edition.

DON E. POULSON, M.D.

French's Index of Differential Diagnosis, 8th Ed.

Edited by A. H. Douthwaite, M.D., F.R.C.P., 1111 pp., $24.00, Williams & Wilkins Company, 1960.

Eighth edition in 48 years of a well known standard work. Some curious flaws are evident even on cursory review: e.g., no mention is made of either pellagra, neurodermatitis, or candidiasis (moniliasis) under surface affections of the scrotum, though these three constitute well over half such cases. The extensively cross referenced index, however, and the generally well presented text material, still make this a valuable reference volume.

HARRY L. ARNOLD, JR., M.D.

Diseases of the Skin

By James Marshall, M.D., 944 pp., $15.00, E. & S. Livingston Ltd., 1960.

Excellently written in clear, simple, concise, words and short sentences. Comprehensive coverage of skin diseases and arranged and presented in an orderly manner. The author devotes adequate space for inclusion of therapies of the various skin disorders and in considerable detail.

The book is replete with illustrations which is a "must" for any dermatology text.

Highly recommended not only for dermatologists but to those doctors in other branches of medicine.

CYRUS LOO, M.D.

★ Highly recommended.

Current Surgical Management II

Edited by John H. Mulholland, M.D., Edwin H. Ellison, M.D., and Stanley R. Friesen, M.D., 347 pp., $8.00, W. B. Saunders Company, 1960.

This is the second in a series. There are sixteen common surgical conditions discussed in this edition, all by qualified authorities.

Each disease discussed is one where distinct differences of opinion exist as to the proper management. It is interesting to read the pros and cons of these surgical controversies.

To the active surgeon this volume will be of considerable interest. To the occasional surgeon it will probably confuse the issue.

DEAN M. WALKER, M.D.

Dr. Judd, Hawaii's Friend

By Gerrit P. Judd, IV, 300 pp., $7.00, University of Hawaii Press, 1960.

In *Dr. Judd, Hawaii's Friend*, the author, Gerrit P. Judd, IV, a great grandson of Dr. Judd gives an unbiased and well documented account of the life of Dr. Judd with special attention to the controversial role he played in the political life of Hawaii. The author had access to material never published previously. For devotees of Hawaiiana, this book is a must. Students of history and of the nineteenth century evangelical movement will find it instructive. The book is as exciting to read as a "whodunit."

Dr. Gerrit Parmele Judd was born into a religious frontier family in western New York in 1803. Raised in an atmosphere of stern devotion to duty, he finished medicine, was converted by the evangelist Finney, and was appointed missionary physician to the Sandwich Island Mission in 1828.

The Hawaiian chiefs came to him first for medical care, and later for advice in government affairs, leading Dr. Judd to resign from the Mission in order to carry out successive appointments in the Hawaiian government. For many years, he was the government, and he transferred all the religious values of the mission to politics. His identification with Hawaii was complete.

Though devoted and conscientious, Dr. Judd's lack of tact, his stubbornness and bluntness brought about his political downfall. His latter years were spent in practicing medicine, experimenting with diversified farming, engaging in the guano trade and in the sugar industry. None of these pursuits brought Dr. Judd any wealth, that reward which the Puritans believed follows an upright life.

But no other white man, before or since, has been so beloved and trusted by the Hawaiians.

The interesting and striking design and typography are by Kenneth Kingrey.

MRS. ROBERT S. HUNTER

★Christopher's Textbook of Surgery, 7th Ed.

By Loyal Davis, M.D., 1551 pp., $15.50, W. B. Saunders Company, 1960.

Christopher's Textbook has long been recognized as an authoritative treatise in the field of surgery. This

(Continued on page 186)

The medical economic challenge of the 60's

Twenty-five years ago in our Islands approximately seventy-five percent of our population could not afford to pay for their medical care. There was much talk at that time that Socialized Medicine was the only possible answer. The HMSA non-profit, voluntary pre-payment medical plan was founded as an answer to this grave community problem. It believed that our community could solve its own medical economic problems through the cooperative efforts of all those affected by the cost of medical care: the public, the medical profession, hospitals, business, labor, educators and clergy.

The success of this concept has exceeded the boldest hopes of even the imaginative founders of HMSA. Today relatively few people in Hawaii cannot afford to pay for their medical care through voluntary medical plans such as HMSA. In fact, HMSA membership alone includes very close to one of every three residents of our Islands.

Our community, through the cooperation of various interest groups, has already done much to prove that we can solve our medical economic problems without the need of government intervention. However, we must continue to prove this in the future. Many problems in this area will have to be solved in the 60's. HMSA believes these problems will be solved and that through community cooperation we can provide all our people with voluntary medical coverage at a cost they can afford to pay.

HAWAII MEDICAL SERVICE ASSOCIATION

A Non-Profit Community Service Organization for Prepaid Health Care

Member, Western Conference of Prepaid Medical Service Plans

Honolulu . . . 1154 Bishop Street — Phone 66-151
Hilo . . . P. O. Box 1356 — Phone 51-855
Wailuku . . . P. O. Box 256 — Phone 323-912
Lihue . . . P. O. Box 27 — Phone 22-201



Infant Death Case Study, No. 9

At 5 A.M. twin girls were delivered of a 17-year-old Gravida I Para II (now) Caucasian mother EDC unknown, under pudendal block after a 10-hour uncomplicated labor in a doctor's office in a rural area. Both twins were born spontaneously, vertex presenting. The BOW had supposedly ruptured at home about 10 hours prior to delivery, but a second sac was found after the delivery of the first twin and this was ruptured with immediate delivery of the second baby. She had had no prenatal care.

Both infants breathed and cried immediately and no resuscitation was necessary. They were transferred to an urban hospital at two hours of age.

The second born twin arrived in good condition—vigorous, with good cry and only minimal acrocyanosis. Weight was 2 lbs. 13 oz. Breath sounds were audible over the entire chest with slight decrease left over right. The infant was given 100,000 units of penicillin and 10 mgm of Achromycin IM on arrival and placed in a Gordon Armstrong incubator with compressed air and mist. Condition was good until about noon of the day of admission when respiratory difficulty developed and within the hour petechiae appeared on the face and lower extremities. About half an hour later the patient became apneic and expired at 1:30 P.M. at 8½ hours of age. Almost complete atelectasis both lungs was found at autopsy.

The first born twin also arrived in good condition and weighed 2 lbs. 4 oz. With the same initial treatment as the other twin she did well and after 24 hours of life was started on 5% G/W by mouth, first 4 cc q3h and this was advanced during the next 32 hours to 12 cc q3h. At this point she was transferred to another urban hospital without any change in her good condition. There she tolerated Alacta formula. She received penicillin and Achromycin only the first two days of life. She pursued an uneventful course for ten days, her weight dropping to a low of 2 lbs. 3 oz. on day 5, leveling off there and increasing by day 9 to 2 lbs. 6 oz.

On day 10 a vesicle was noted for the first time on the pinna of the left ear. On the following day several more vesicles erupted about the left side of the face. With this the infant began to feed less well and gradually lost weight. Bacteriological culture of the vesicles was sterile and the lesions spread despite local bacitracin treatment and Ilotycin orally, both started on day 11. On day 12 Chloromycetin 20 mg/kg/day was started and ½ cc of gamma globulin was given IM. The infant's general condition deteriorated in terms of feedings, activity, and general appearance. On day 13 Ilotycin was discontinued and penicillin and streptomycin were instituted and continued for four days at which time the clinical picture was worse and these drugs were felt to be of no value. Gamma globulin ½ cc was administered again on day 17 when a tentative identification of virus of herpes simplex was returned. On day 19 the infant died after a convulsive seizure. At autopsy, tissue necrosis was found scattered through the brain, lungs and adrenals. Herpes simplex virus was cultured and identified from vesicle fluid and brain tissue.

Discussion: In general and as specifically regards the death of the second-born twin, one cannot reiterate too frequently the importance of good history and prenatal care in order to suspect and confirm the presence of more than one infant prior to delivery. This in itself allows adequate obstetrical preparation for the hazards of multiple birth as well as presence of pediatric aid for management of the infants. Pediatric care of twins should involve careful initial examination and observation as keen as for the premature during the first 48 hours, regardless of the size of the infant.

Of special interest here is the rare and lethal affliction of the first twin. Though generally a benign isolated vesicular dermatitis, in certain instances, herpes simplex may be a generalized infection involving any or all of the organs of the body. The organism is generally thought to be transmitted to the newborn from the mother, with first signs and symptoms usually occurring between the 5th and 9th day of life. The clinical picture may include any or all of the following: Decrease in feedings, weight loss, increase in icterus, dehydration, vesicular dermatitis which may be absent, minimal or wide spread. These initial findings then proceed to lethargy and stupor, episodes of apnea and death is most often preceded by cardio-vascular collapse or convulsions. In the newborn this infection has been universally fatal despite all treatment, including massive doses of gamma globulin, steroids, and supportive care.

Classification: Twin who died within eight hours—preventable from an obstetric standpoint. Twin who died on the nineteenth postpartum day—preventable from an obstetric standpoint, nonpreventable from a pediatric standpoint.

One of a series of case reports prepared by the Advisory Committee to the Bureau of Maternal and Child Health to illustrate the type of study made in the instance of an infant or maternal death in Hawaii.

Notes and News

The new editor of this section is launched with this issue. Being a rank novice—and in an effort to make this department readable, informative, and live—he welcomes any comments, criticisms, or interesting news item. So, let's have some cooperation. Call the HMA office and let us in on the news—and even "hush-hush" gossip.

Travel News

Dr. Duke Cho Choy and family recently spent a pleasant few weeks in Belvedere, California. Some of his golf pals feel that they sponsored the trip.

Dr. W. H. Kuroshige and family vacationed on the West Coast, motoring from Los Angeles to Vancouver. **Dr. H. S. Dickson** reports wonderful traveling and fishing in Idaho. His *opu* attests to this. He reports meeting **Gus Rosenheim,** former Kapiolani resident, in Boise. **Dr. Fred Gilbert** is spending a year in London, studying . . . ditto **Dr. R. Dusendschon,** who is in Cincinnati.

Enjoying the sights in Europe this past summer were **Dr. and Mrs. Rodney T. West,** the **Som Allisons,** and the **Fred Gileses. Dr. T. Shinkowo** also traveled through Europe but in addition continued around the world. He recommends the trip.

Orient touring has been done by **Dr. and Mrs. H. Johnson. M. Kimuro** and family report a wonderful four weeks spent in Japan. **Dr. T. F. Fujiworo** and family enjoyed a fabulous trip to the Orient this summer.

New Affiliations

Dr. Richard Ando, our hard working temporary chairman of the Hawaii Physicians League for Good Government, has exercised his rights as a citizen and is flashing a brand new Democratic Party card, one of the few avowed Democrats in the profession. He is actively participating in precinct and party functions. More in the profession should be card carrying members, no matter which party they wish to join.

Dr. Thomas W. Cowon has announced his association with **Dr. Robert Koiser,** a Bellingham, Washington, ophthalmologist.

New Faces

Dr. Alvin A. C. Poroz (GP) has settled at the Nuuanu Clinic at 1741 Nuuanu Avenue. Surgeon **Albert K. S. Chun** is hanging his shingle at 338 So. Vineyard. Pediatrician **J. A. Mertz** and GP **Felix Lofferty** have been added to the Medical Group. **Dovid Sinclair** (Ob-Gyn) has joined **Cushnie, Dickson, Chung-Hoon** and **Ookley** at the Young Hotel Bldg. **George Suzuki** (internist) has just opened his office at the Medical Arts Bldg. **Arthur K. Wong,** also an internist, has been added to the **Chang-Wakai** duo. **Ed. F. Furukowo** has located in the Occidental Bldg. He is a psychiatrist. **Allon H. W. Young** (GP) has gone into association with **Dr. Ed Lee** at the Professional Center Bldg. . . . and **Carl H. Lum** (General Surgeon) is located at 1505 So. King St.

We welcome them to the brotherhood of physicians, hoping that each will contribute his talents to the efforts of the Medical Association.

Names in the News

The profession noted with sadness the passing of **Dr. Erwin Cheim,** Director of the V.A. Outpatient Clinic. All who have had dealings with him have nothing but praise for his efforts on behalf of the veterans and medical profession.

Dr. Richard K. C. Lee, our genial director of the Health Department, was recently elected Chairman of the World Health Organization, Pacific Regional Committee, at its annual session in Manila. Dick has also been honored with an appointment to the Western Council on Mental Health Training and Research of The Western Interstate Commission for Higher Education.

Prexy Ed Cushnie welcomed the SS "Hope" when it docked at Pier 8 recently . . . **Dr. Mory A. Glover** will be Hawaii's sole representative aboard the SS "Hope" on its mercy mission to Indonesia.

Drs. William S. Ito, Toru Nishigoyo, and **Satoru Nishijimo,** and 95-year-old **Dr. I. Kotsuki** received prominent display in the U. S. Japan Centennial edition of *The Honolulu Advertiser.* Seen at the Governor's reception for the Crown Prince and Princess Akihito of Japan and hobnobbing with the elite were the **Tokeo Fujiis, Tom Fujiworo** and daughter Kathy, **Howord Hondos, William Ito, Homer Izumis, Kikuo Kuramotos, Komsat Ng, Toru Nishigoyos, Rondol Nishijimas, Richord Sokimotos, Ted Tomitos, Herbert Takakis,** and **Goonzo Yamoshitas.**

Dr. Groce Hedgcock retired after 11 years as Medical Director of Hale Mohalu, on September 20. She was honored at a testimonial dinner sponsored by friends . . . **Dr. Shoyei Yomouchi** has been selected as one of the eleven delegates to the White House Conference on aging to be held in January, 1961 . . . **Drs. John Frozer** and **Richord Sokimoto** attended the Western Conference of Prepaid Medical Service Plans in Winnipeg as HMSA representatives in October. **Dr. Richard You** just returned from the Olympic Games in Rome. He served in his usual capacity as one of the physicians for the U. S. Olympic Teams. He also roamed around in Europe for several weeks taking in the sights.

Congratulations to **Dr. Bernord Fong** on his election as President of the Hawaii Heart Association . . . also to **Dr. Potrick Cockett,** new head of the Hawaii Plantation Physicians Association. **Dr. Clarence E. Fronk** belatedly received two service awards from Admiral H. G. Hopwood.

Physicians getting into the field of higher education are **Drs. Williom Bergin** (past HMA President), **Cesor De Jesus, John Felix, Leslie Vosconcellos,** and **John Chalmers,** who were recently appointed on the Academic Lay Advisory Board of Chaminade College.

Not too pleasant news was made recently by the **Pocific Medicol Associates.** Their running battle with Henry J. made headlines for several weeks. They are now located at 620 McCully Street. Welcome back to the fold!

Newlyweds **Robert Alexonder Rose** and wife are at home at 44-483 Kaneohe Bay Drive. The bride was given away by **Dr. R. W. You** . . . Former Narcissus Queen Carolyn Tong and **Dr. Roymond Chong** tied the knot recently and are at home in Waialae-Kahala. Congratulations!

ERWIN CHEIM, M.D.
1900-1960

Dr. Erwin Cheim died suddenly on September 17, 1960, after almost fourteen years of medical service to veterans in Hawaii. As Medical Director of the Outpatient Clinic of the Veterans Administration, Dr. Cheim was responsible for the treatment of thousands of island veterans who came to respect him as a physician and value him as a counselor and friend. Tragically, he never set foot in the new and more modern clinic which he had helped to plan and which was first occupied the week after his death.

Dr. Cheim was born November 9, 1900, in Thorn, Germany. Sixteen generations of distinguished rabbis had made the family name well known throughout Eastern Europe. He graduated from the Royal Gymnasium of Thorn, then attended the University of Breslau and received his M.D. degree from the University of Kiel after completing a year's internship in the Jewish Hospital in Berlin. During the following years, he was attached to the outpatient clinics of the University Hospital and other hospitals in Berlin, and engaged in private practice in that city. On October 17, 1930, he married Emilie Millie Koppel, a Berlin fashion designer.

Dr. and Mrs. Cheim fled Germany in 1933 to escape Nazi persecution, and spent the next two years in France, where he was associated with the Department of Internal Medicine at Salpêtrière Hospital in Paris. In May, 1935, Dr. Cheim came to this country and, shortly thereafter, he entered private practice in Brooklyn, New York. In 1941, he acquired American citizenship.

Dr. Cheim was personally instrumental in the rescue of sixteen families from Nazi Germany, and bringing them to this country, where he guaranteed their support in case of need.

He was commissioned a Captain in the Medical Corps of the United States Army in 1943. In 1944, he was sent overseas to Europe, where he served with distinction in combat areas as a battalion surgeon.

After his discharge from the army, he entered the service of the Veterans Administration in the Department of Medicine and Surgery, and was assigned to the Regional Office in San Francisco, California. On December 1, 1946, he was transferred to the Honolulu Regional Office. He became Chief Medical Officer on March 16, 1953. Although he was charged with administrative responsibilities, he continued to maintain his interest in clinical medicine, especially in the fields of cardiovascular and pulmonary diseases.

Dr. Cheim was a quiet but friendly person with a touch of continental charm, a quick mind, and a special aptitude for dealing with facts and figures. During his undergraduate days, he was considered a brilliant student in mathematics. Bridge, which was his principal hobby, as well as a source of distinction, had earned him many admirers among a great variety of the people in the Islands. He was a Life Master and had won many Hawaiian tournaments in competition with national experts.

Dr. Cheim was a member of the American Medical Association, Honolulu County Medical Society, the American College of Cardiology, and the American Society of Tropical Medicine and Hygiene. Mrs. Cheim is his only surviving relative in Hawaii.

SOLOMON B. MEYERSON, M.D.

THOUGHTS

Sir Thomas Browne said, "Think not Silence the wisdom of Fools, but if rightly timed, the honour of wise Men, who have not the Infirmity, but the Virtue of Taciturnity, and speak not out of abundance, but well-weighed thoughts of their Hearts. Such Silence may be Eloquence, and speak their worth above the power of Words."

County Society Reports

Hawaii

The Hawaii County Medical Society held its monthly meeting July 21, 1960, at the Hilo Hotel.

Dr. Miyamoto reported on the survey of the University of Hawaii, Hilo Campus (UHHC) in regard to the possibility of the Medical Society's sponsoring a scholarship: (1) The courses available are in education, business, arts and science, English, and home economics; (2) The cost per semester is $85.00 for tuition, $10.00 for registration, $10.00 for ASUH fee, $10.00 course fee, and approximately $40.00 for books; (3) A Faculty Scholarship Committee is available to help select the recipient. A motion was made by Dr. Mitchel, seconded by Dr. Woo, and carried, that the Society sponsor a Freshman Scholarship to the UHHC to begin this fall.

Dr. Hata read a letter received from HMSA to the effect that the Medical Director's Fund was almost depleted, and that all the participating physicians will be charged 0.2% of their year's account, which will be deducted from the December, 1960, payment.

Dr. Okumoto stated that the panel of specialists on the Medical Social Service was incomplete, since only the surgeons are listed on the panel. Suggestion was made that Drs. Ruth Oda and Edward Wong be placed on the panel as specialists in pediatrics, and Drs. Robert Henderson and M. L. Chang as specialists in cardiology. It was further suggested that the fee range from $10.00 to $50.00, depending on the amount of time spent in rendering the service. The suggestion was made into a motion by Dr. Miyamoto, seconded by Dr. Wipperman, and unanimously carried.

Dr. Walter Griggs wrote to the Society requesting a change in the status of his membership while in residency training in New York. Dr. Miyamoto moved, seconded by Dr. Yuen, and carried, that Dr. Griggs be placed on the inactive list.

A letter was received from Mr. D. E. Larsen of Hamakua Sugar Company stating that he was having difficulty in getting a Dr. Wilmot Boone on Guam to replace Dr. Musser as plantation physician because he lacked Hawaiian licensure. After some discussion, it was decided that the Society write to the State Board of Medical Examiners recommending a waiver of the residency requirement for Dr. Boone on the basis of need for a physician in Paauilo.

Civil Defense Headquarters in Honolulu wrote to the Society stating that Drs. Lau and Quisenberry would be available for Civil Defense demonstrations. A motion was made by Dr. Wipperman, seconded by Dr. Loo, and carried that such a demonstration be held at Pumaile Hospital auditorium on August 4, inviting the dentists and nurses.

Following the business meeting, Dr. William Mayer spoke on two subjects: 1. Current Philosophy, Methods, and Plan in the Rehabilitation, and Community Outpatient Care of Patients Discharged from the State Mental Hospital; 2. Attitude Studies of Americans Serving in the Far East.

* * *

The Hawaii County Medical Society held its monthly meeting on August 25, 1960, at the Hilo Hotel.

Dr. Hata introduced Dr. Yonemichi Miyashiro to the members of the Society as a newcomer. He is presently the attending physician at Paauhau Sugar Company.

Dr. Wipperman made the recommendation to unify the doctors on the Disaster Committee of the county, social agencies, hospital, and the local medical society into a Joint Committee so that coordination of the medical work can be more effectively executed. He also recommended that the members of the Disaster Committee of the hospital and medical society make up the Joint Committee. Dr. Okumoto made the motion to accept the recommendation of Dr. Wipperman, and this was seconded by Dr. Miyamoto. The motion was carried unanimously.

The local Cancer Society sent some poster materials on the subject "To Smoke or Not to Smoke," and requested endorsement by the Medical Society. The posters are being displayed in the various schools through the Department of Public Instruction. Motion for the endorsement was made by Dr. Miyamoto, seconded by Dr. Okumoto, and carried.

The matter of paying the delegates for their expenses in attending the Hawaii Medical Association meeting was brought up. Dr. Henderson made the recommendation to pay the delegates' plane fare plus $10.00 per diem. A motion to pay the delegates this year, but hereafter not to pay them, was not carried.

Following the business meeting, Dr. Ruth Oda gave an interesting talk on "Meningococcemia and Its Complications." After the talk, a movie film "Diagnostic and Therapeutic Advances in Liver Diseases" was shown.

TOKUSO TANIGUCHI, M.D.
Secretary

Honolulu

A special meeting was held Monday, June 27, 1960 President H. Q. Pang presided and approximately 11(members were present.

Dr. Ross Y. Hagino, new active member, was acknowl edged.

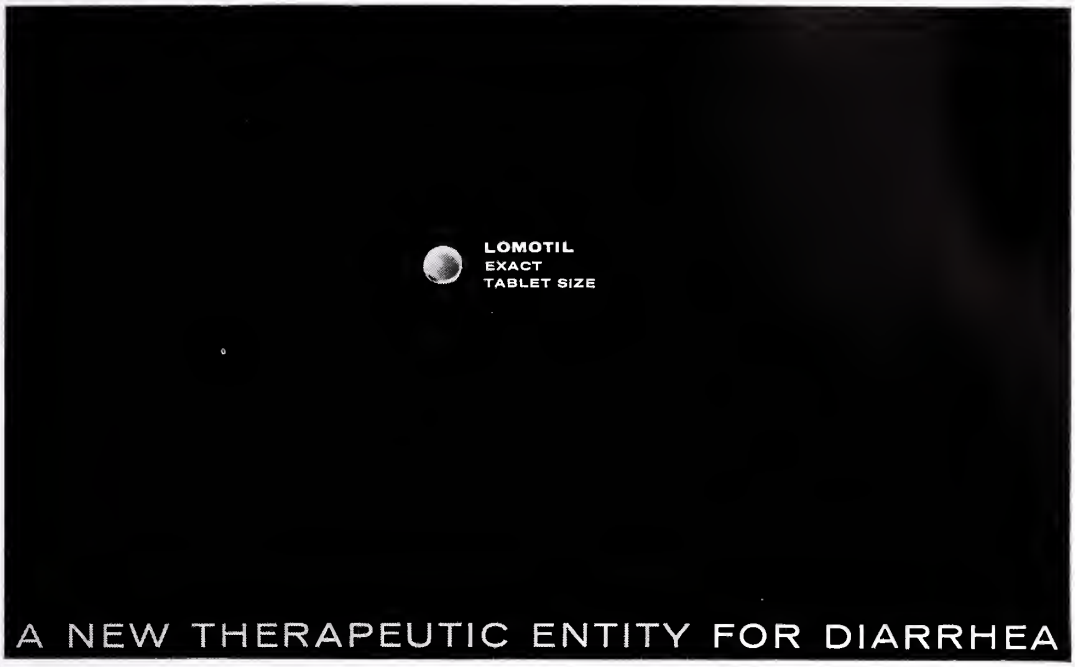
A telegram from the AMA and an excerpt from th Washington Report regarding H.R. 12580 was rea urging all doctors to write to the Senators to (1) recom mend hearings by the Senate Finance Committee an (2) vote against any OASDI amendment that include a health care benefit. Dr. Hartwell and Dr. Arnold, Jr. also commented on the bill and both urged the mem bership to take a few minutes to write to Senators Lon and Fong in reference to this bill.

Workmen's Compensation Fee Schedule

Mr. Kennedy stated that the Fee Adjustment Com mittee would like the Society to vote on the new Work men's Compensation Fee Schedule by mail ballot rathe than calling a special meeting.

Mr. Kennedy then made a verbal report of the presen status of the Fee Adjustment Committee's negotiation with the Workmen's Compensation Bureau. The Com mittee went into the negotiations with the idea of con verting completely to the Relative Value Schedule. How ever, it became apparent that they would not convert t the $4.50 conversion factor. As it stands now they hav tentatively agreed to accept the HMSA's surgical fe schedule with minor changes in the orthopedic section and in the medical section $5.00 has been accepted fo a first office visit and $4.00 for subsequent office visit

(Continued on page 188)



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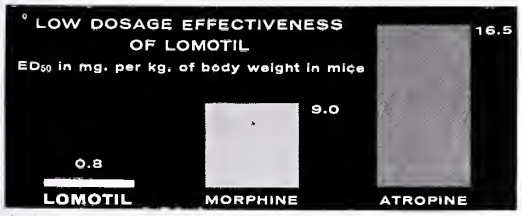
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PRECAUTION: While it is necessary to classify Lomotil as a narcotic, no instance of addiction has been encountered in patients taking therapeutic doses. The abuse liability of Lomotil is comparable with that of codeine. Patients have taken therapeutic doses of Lomotil daily for as long as 300 days without showing withdrawal symptoms, even when challenged with nalorphine.

Recommended dosages should not be exceeded.

DOSAGE: The recommended initial dosage for adults is two tablets (5 mg.) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is supplied as unscored, uncoated white tablets of 2.5 mg., each containing 0.025 mg. (1/2400 gr.) of atropine sulfate to discourage deliberate overdosage.

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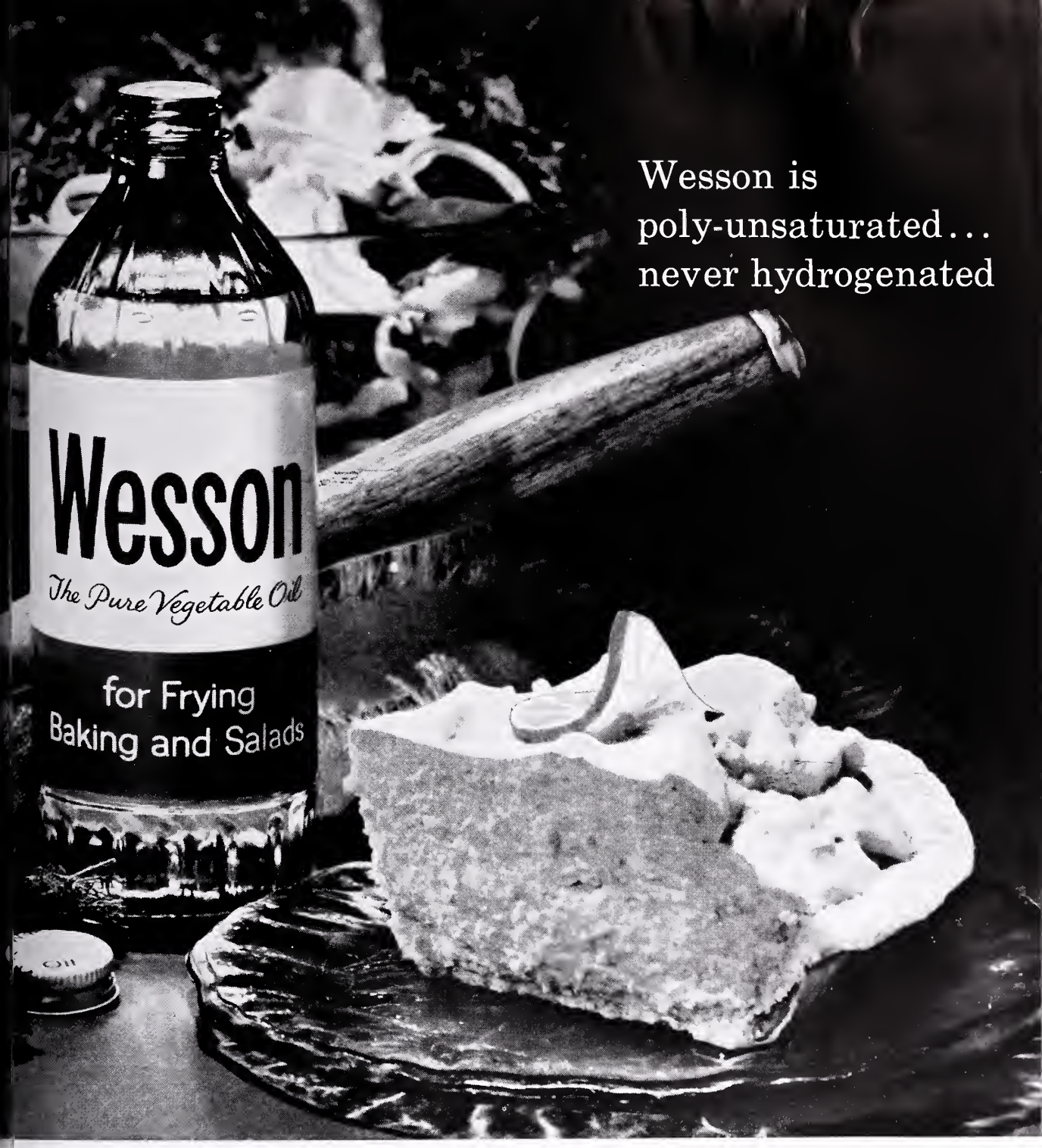
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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Hawaii Nurses Association

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1960-1961

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* Term of office—3 years. Two directors are elected each year. Terms of section chairmen are according to the rules of each section.

General Interest

Visiting Professor

Miss Margaret S. Taylor arrived in Honolulu n September to take over her duties as visiting ›rofessor of nursing at the University of Hawaii 'or the 1960-61 academic year. Sponsored by a grant from the China Medical Board Inc., of New York, she will act as consultant in curriculum development of the College of Nursing.



MISS TAYLOR

Miss Taylor, a member of the National Advisory Committees on Health and Rehabilitation, holds both B.S. and M.A. degrees from Columbia University's Teachers College. She did graduate work at University of Buffalo, University of Minnesota, and New York School of Social Research.

Currently on leave from the University of California Medical Center, San Francisco, she specializes in public health nursing. Various consultant positions with the federal government include Chief Nurse for the Health Branch of Bureau of Indian Affairs, Department of Interior, and for the Public Health Service, Department of Health, Education, and Welfare. She has also been on the faculty of University of California at Los Angeles and University of Minnesota.

Her travels include the entire United States as well as Brazil, Chile, and Columbia which she visited as a World Health Organization Fellow.

1960 Facts About Nursing

A median monthly salary of $300 per month s paid to general duty nurses working in non-federal general hospitals in the United States today and the *top* nursing position in these hospitals —that of the director of nursing service—pays a median monthly salary of only $425 per month!

These figures come from the 1960 edition of *Facts About Nursing,* just published by the American Nurses' Association. *Facts* contains information on the distribution of nursing resources, salaries of nurses, facts about nursing education and data on allied nursing personnel.

Information on the characteristic of professional registered nurses is also available in the 1960 *Facts About Nursing*. This year, for the first time, material from 48 state inventories is included. Inventory findings reveal that 99 out of every 100 registered nurses are women and more than half of them are married. Only about three out of every ten employed nurses are single. The majority of nurses practicing today are less than 45 years of age, but the proportion of nurses in the higher age brackets has been increasing and about three out of every ten are 45 years or older.

Data on the salaries of hospital nurses (inventory findings reveal that more than half of the active professional nurses are engaged in hospital nursing) is based on a survey of employment conditions in nonfederal general hospitals conducted by ANA in February, 1959. The survey showed that the salaries were highest in the Pacific region of the United States; higher-than-average salaries were paid in the Great Lakes region and, for the higher level positions, in the Middle Atlantic region. Nurses in the Southeast region earned the lowest in the country. Salaries also were affected by the size of the hospital. Nurses who worked in larger hospitals tended to have higher salaries than those who were in hospitals with smaller bed capacities.

The U. S. Army Nurse Corps

The United States Army Medical Service Historical Unit in Washington, D. C., under the direction of The Surgeon General, is engaged in the preparation of the History of The United States Army Nurse Corps.

The introductory portion of this volume will depict by historical example and analogy, the background that led to the establishment of the Army Nurse Corps. Other portions will be devoted to the discussion of the detailed organization, administration aspects, and professional achievements of the Army Nurse Corps.

Reference material of a historical nature such as records or articles of professional and scientific significance, personal letters, journals, speeches, and photographs which relate to the activities of the Army Nurse Corps are needed to highlight and augment official references.

It will be greatly appreciated if individuals who possess such material will forward it directly to:

Director
Historical Unit, USAMEDS
Forest Glen Section, WRAMC
Washington 12, D. C.

Any material forwarded to the Historical Unit will be returned to the owner after duplication of

this material, if that is the individual's wish or if desired and indicated, the material will be retained and filed in the Historical Unit.

ANA Notes

Appointment of ANA committees for the 1960-62 biennium, naming of ANA delegates to the ICN Congress in Australia next April and matters relating to improvement of nursing standards and practice were on the agenda of the newly-elected ANA Board of Directors at its first meeting, August 4-6, since its brief post-convention session in Miami Beach last spring. All 22 members of the Board were present for the meeting presided over by ANA President Mathilda Scheuer.

* * *

A statement enunciating standards for nursing care in nursing homes has just been completed by ANA as a guide to improved care in the increasing number of these institutions throughout the country.

The statement emphasizes that skilled nursing care is a necessity in nursing homes and states that there should be direct supervising of nursing care by a registered professional nurse. It lists 17 standards for achieving and maintaining a desirable quality of nursing care. The statement also notes that general improvement of employment conditions is essential to improvement of patient care in nursing homes.

Copies will be supplied in the immediate future to state nurses associations, appropriate governmental agencies, allied health organizations and other interested groups.

The statement is being sent at once to the U. S. Public Health Service for use in preparation of a planned guide on standards for nursing homes to be released to state licensing agencies later this year.

These standards were formulated by ANA's Committee on Allied Nursing Personnel following review of the current situation in regard to nursing homes and with particular attention to the characteristics of those primarily comprising the patients in these homes—the aged and chronically ill.

* * *

The importance of continuing and increased attention by ANA to meeting the clinical interests of members was stressed in a report from the Study Committee on the Functions of ANA. This committee is identifying functions which should be performed by the professional organization and assessing how well they are being carried out.

It recommended that at least one day be devoted to clinical sessions at the 1962 ANA Convention.

The Study Committee also plans to have a report for presentation at a meeting of SNA representatives which will be scheduled for the latter half of 1961.

* * *

Increasing emphasis by ANA on providing the means for members to improve their practice was evidenced in preliminary plans presented for section regional conferences to be held in four areas of the country next February and March. The conferences will focus on "The Improvement of Nursing Practice," and will include talks and discussion on various aspects of individualized care and continuing development of the nurse practitioner.

Conferences will be held in New York, Feb. 14-17; Portland, Ore., Feb. 28-March 3; Denver, March 5-8, and St. Louis, March 15-18.

* * *

In still another step toward assumption of greater responsibility in the area of nursing practice, establishment was approved of an Intersectional Committee on Nursing Practice. It will be composed of a representative from the Committee on Functions, Standards and Qualifications for Practice of each of the ANA sections and branches. Its functions will be to (1) consider those matters of common interest and responsibility to all areas of nursing and related to nursing practice (2) assist in defining and interpreting the principles and standards of nursing practice to which the profession is committed (3) provide continuing and coordinated guidance to the SNA committees on nursing practice, and (4) develop recommendations for ANA program development in the area of clinical practice and patient care.

Members will be appointed by sections and branches this fall.

* * *

Five official delegates will represent ANA at the Twelfth Quadrennial Congress of the International Council of Nurses in Melbourne, Australia April 17-22, 1961: Mathilda Scheuer, ANA president; Mrs. Judith G. Whitaker, executive secretary; Mrs. Margaret Dolan, second vice-president; Sister Maureen and Mrs. Anne Zimmerman, members of the ANA Board of Directors.

As ANA president, Miss Scheuer is also a member of the ICN Board of Directors which will meet in Wellington, New Zealand preceding the Congress.

All ANA members are eligible to attend the Congress. Application forms can be secured from ANA Headquarters, 10 Columbus Circle, New York 19, N. Y.

ANA Regional Conferences

How can professional nurses initiate patient-entered care? How can they participate more fully n decisions affecting quality patient care? What ust professional nurses know to provide effec-ve management of patient care? Discussion on ese and other crucial questions will be featured : ANA's Regional Conferences to be held next ebruary and March.

Conferences will focus on the "Improvement of Jursing Practice." Nurse leaders will identify bstacles to the advancement of patient-centered ire and promising approaches to promoting qual-y nursing care. Addresses and discussion meet-ngs will cover both clinical and professional as-ects of nursing practice.

Open to all professional nurses, the conferences ill take place February 14-17, Hotel New Yorker, Jew York City; February 28-March 3, Memorial oliseum, Portland, Ore.; March 5-8, Hotel Den-er-Hilton, Denver, Colo.; March 15-18, Hotel hase-Park Plaza, St. Louis, Mo.

To provide the most effective setting for group iscussions, attendance at each conference will be mited. All nurses must register in advance and ndicate their participation in two major discus-on topics. Registration fee will be $15 for ANA iembers; $30 for nonmembers, payable at each nference. Copies of all major addresses and roup reports will be distributed to every regis-ant at each conference.

Early registration is advised. Deadline for reg-tration is January 15, or sooner if attendance uotas are filled before that date. Registration rms are available now from your SNA office from: Section Regional Conferences, ANA adquarters, 10 Columbus Circle, New York 19, N. Y. The form will be carried in the November issue of *The American Journal of Nursing* and in the Winter 1960 issue of *ANA in Review*.

Scholarships

Scholarship courses in rehabilitation nursing will be conducted throughout 1961 at Elizabeth Kenny Institute, Minneapolis, Minn.

Of three weeks' duration and offered eight times during 1961, the courses are designed especially for nursing instructors, nursing supervisors, head nurses, and public health nurses. The complete in-residence programs include instruction through lectures and clinical experience on the wards with hemiplegics, paraplegics, quadriplegics, amputees, and patients with poliomyelitis, cerebral palsy and other severely disabling conditions.

The courses are planned primarily to emphasize the nurse's role in the bedside care of the physically disabled patient with special reference to prevention of complications which might prolong the rehabilitation process or prevent good results.

Much of the course content consists of newly-developed and refined nursing techniques that are outgrowths of the Kenny Institute's expanded neuromuscular rehabilitation program.

Courses are scheduled for these dates in 1961: January 9-27; February 27 through March 17; April 17 through May 5; June 5-23; July 24 through August 11; September 11-29; October 16 through November 3; November 27 through December 15.

Additional information can be secured by writing Catherine Haas, R.N., clinical instructor, Elizabeth Kenny Institute, 1800 Chicago, Minneapolis 4, Minn.

District and Section News

Maui

Two new registered nurses have recently been mployed by Molokai Community Hospital, Mrs. Marian Larsen and Miss Vera Olsson. Mrs. Lar-en is a graduate of St. Lukes in Minnesota. She as employed at St. Louis City Hospital and itzsimmons before coming to Hawaii. Miss lsson is from Lasarutt, Sweden and a graduate f Sundsvalls Hospital. Before coming to Hawaii e worked at Cedars of Lebanon Hospital for ur years.

* * *

Mrs. Grace Apo, Head Nurse at Molokai Com-unity Hospital, returned last month from an tended trip to the mainland. She was accom-panied by her husband. Both report a fine trip and wished for a longer stay.

* * *

A dinner meeting of the Molokai Registered Nurses' Club was held at the home of Laura Yamamoto Wednesday, October 14, 1959, for the purpose of electing officers and planning future programs. Seven members attended with two absent. Special guests were Mrs. Larsen and Miss Olsson. Officers elected were Mrs. Marion (Lau) Stevens, President, and Mrs. Julia Coelho, re-elected Secretary-Treasurer. New committee chairmen appointed were Miriam Davis, Program, and Laura Yamamoto, Publicity. Date of the next meeting will be announced later.



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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

CAROLYN E. MCCUE, *Editor* BERYL UYEHARA, *Associate Editor*

Editor's Note

The editors will appreciate and wish to encourage Journal contributions from our members. We will consider for publication anything from original research papers to wedding announcements. We should also like book reviews, journal abstracts, work simplification ideas, reports, and opinions of new methods and equipment tested in your laboratories. We should especially like to hear from laboratories or individual technologists on the neighbor islands and rural Oahu whom we cannot interview personally.

* * *

Laboratory staff personnel from St. Francis and Kaiser Hospitals were among the many Honolulans who toured the hospital ship "Hope" during its two-day stay in Honolulu. Seven registered medical technologists, some with advance degrees, form the ship's laboratory complement. The laboratory was not completely set up at time of inspection, but it is equipped to carry out all routine procedures done in any large hospital in this country. The technologists expect to rotate the departmental duties. A major part of their work in Indonesia will be the training of laboratory personnel. One technologist interviewed emphasized, however, that the Americans expect to learn a good deal too, particularly in the field of tropical parasitology. We envy them, their opportunity.

Mrs. Dorothy Matsuo, chief technologist at Children's Hospital in Honolulu, has returned to the Islands after a five-week stay in Denver. Mrs. Matsuo was sent by Children's Hospital to the Colorado General Hospital to study methods and techniques used in the micro-chemistry laboratory there. The laboratory is headed by Dr. Donough O'Brien. Dr. O'Brien addressed the Hawaii Society of Medical Technologists on techniques of microchemistry, and is remembered by our members as one of the most entertaining guest speakers ever presented. Mrs. Matsuo worked with both Dr. O'Brien and Mr. Frank Ibbott, chief technologist, who co-authored *Laboratory Manual of Pediatric Micro-Biochemical Techniques (1959)* with Dr. O'Brien.

All chemical determinations are done on micro basis; that is, using 200 lambda (0.2 ml or smaller samples. The emphasis now is on th development of ultra-micro tests using samples o 10-20 lambda. Mrs. Matsuo reports that ultra micro methods for calcium and chloride are bein used with a high degree of accuracy. Howeve methods for quantitation of other constituent such as cholesterol, have not yet been perfecte

Mrs. Matsuo plans to adapt many of the micr methods for use at Children's Hospital Laborator

* * *

Guest speaker, Ralph V. Platou, M.D., head o the Department of Pediatrics at Tulane Unive sity and President of the American Board o Pediatrics, outlined the various criteria for diag nosing mongolism in children at the August mee ing. Laboratory tests, helpful in the diagnosi were chromosonal counts and marrow or tissu cultures.

* * *

A dinner meeting was held on September 13 a the Willows. Guest speaker was Dr. Robert A Nordyke, M.D., an internist with a subspecialty i nuclear medicine. He discussed recent develop ments in the use of radioactive isotopes in diag nostic laboratory procedures including tests fo kidney, thyroid, liver, and digestive tract fun tions. These tests in time will replace many o our standard clinical chemistry procedures.

Guests present were Mrs. Robert Nordyk Dr. Wilhelmina Haake, Education Director Children's Hospital; Mrs. Ann Isoshima Han mura, visiting from Japan; and Mrs. Rochell West, M.T., a newcomer to our State.

News

The following medical technology students a welcomed to HSMT as student members:

Kuakini Hospital—Shoichi Tamura, Joyce Watanab
The Queen's Hospital—Jean Fujimoto
St. Francis Hospital—Carol Fujii, Max Bowman, Mar Ellen Meyer
Tripler Army Hospital—Ray Akaka, Bernice Tamur Roger Bautista, Edward Stowers

On September 24, Science Clubs Hawaii chose ublic health and the role of the Department of Health as its topic for their televised program. HSMT members shown at work on serological ests were Satsue Fujishima and Harriet Nakano.

Correspondence

The following correspondence is relative to the HSMT efforts to increase salaries for medical echnologists employed in the State of Hawaii.

June 22, 1960

L. Tilden, M.D., President
lawaii Society of Pathologists
lonolulu, Hawaii

)ear Dr. Tilden,

The Hawaii Society of Medical Technologists, follow- ıg the suggestion of the Hawaii Society of Pathologists,)nducted a wage survey through a special committee eaded by Mrs. Elizabeth Hughes. The aims of the)mmittee were:

1) Briefly survey prevailing wages of medical tech- ologists and of other positions in allied fields.

2) To suggest a wage scale for technologists, attrac- ve enough to limit turnovers with due consideration of)erating costs for hospitals and clinics.

The following is the wage scale recommended by the)mmittee and approved by the Hawaii Society of Med- al Technologists:

Chief Technologist	$500–$620
Head of Department	$450–$570
Medical Technologist	$440–$520
ASCP eligible	$390

A yearly increment of $15 a month for a total of ght years brings each starting salary to its maximum. This recommendation is being submitted after much iscussion by the members of our group at a business ieeting held on June 16, 1960. We feel that it fulfills ie purpose of the wage survey in that it is both at- active enough and realistic in the light of the informa- on submitted by the committee and enclosed herewith.

We sincerely thank you for your interests in our be- alf and hope that you will be in agreement with our ecommendations.

Respectfully submitted,

DOROTHY MATSUO, *President*
HSMT

A copy of the wage survey was submitted with ie above letter, but is not being reproduced here.

* * *

August 16, 1960

Mrs. Dorothy Matsuo, President
Hawaii Society of Medical Technologists

)ear Mrs. Matsuo:

At its regular meeting, held on August 14, 1960, the Hawaii Society of Pathologists acknowledged the receipt of your letter concerning changes in the salary scale for laboratory technologists in this community. It has been decided to support these requests, with one amendment: that registered technologists without a college degree have a starting salary of $350 per month. It is also suggested that some consideration be given to technologist's experience, when setting the salary scale.

We further recommend that your society communicate with the administrative offices of the hospitals concerned, stating your requests and noting our support of same.

Should further action in this matter be required we recommend a meeting of your executive officers with our group at a mutually convenient time.

Sincerely yours,

GRANT N. STEMMERMANN, M.D.
Secretary

Copies of the following letter were sent to the administrators of all hospitals in Hawaii.

August 30, 1960

Dear _____

The Hawaii Society of Medical Technologists at the August 16 meeting voted to submit the following salary scale to all hospital administrators in Hawaii. The Hawaii Society of Pathologists has studied our proposed salary scale and at its last meeting decided to support it.

Chief Medical Technologist	$500–$620
Head of Department	$450–$570
Med. Tech., degree, reg., exp	$425–$525
Med. Tech., degree, registered	$400–$520
Med. Tech., degree, ASCP eligible	$390
Med. Tech., no degree, registered	$350–$450
Med. Tech., no degree, ASCP eligible	$340

The above scale was proposed after a survey of salaries in Hawaii, California, and other areas was made. A copy of this survey is enclosed with a copy of our correspondence with the Hawaii Society of Pathologists.

The Hawaii Society of Medical Technologists feels that salary increases for medical technologists have fallen far behind those increases awarded other professional groups. For example, ten years ago, in 1950, a registered medical technologist with a degree received a starting salary of $250 per month, as compared to a school teacher, Class II, whose starting salary was $200 a month (a difference of $50). At the present time, as can be seen by the survey, the medical technologist instead of receiving the higher starting salary receives a lower starting salary.

With general salary increases being considered, the Hawaii Society of Medical Technologists respectfully requests that the proposed salary scale be carefully considered.

Sincerely yours,
LORENE LEONG
President

(Continued from page 169)

Seventh Edition, under the able supervision of Loyal Davis as Editor, with chapters contributed by 82 well-recognized leaders in the field to which their discussions are limited, plus many illustrations, make the book a valuable addition to the libraries of all medical students. Since medical men are of necessity always students, its appeal should be universal. Many recent advances in all aspects of surgery have been added, and outmoded and obsolete practices deleted.

While it must be recognized that all textbooks become outmoded in a comparatively short period of time due to unprecedented advances being made, *Christopher's Textbook of Surgery* at the moment contains the most modern and generally accepted viewpoints covering the entire field of surgery. It is impossible in a book so voluminous as this one to point out its many admirable features. However, I would suggest that the chapter on "The Qualifications of a Surgeon" and the one on "Surgical Judgment" be read carefully, particularly by surgeons just beginning their professional careers.

J. E. STRODE, M.D.

Also Received

★Arthritis and Allied Conditions, 6th Ed.

Edited by Joseph Lee Hollander, M.D., 1,306 pp., $20.00, Lea & Febiger, 1960.

Eight editors and 30 eminent contributors have helped Dr. Hollander completely revise and rewrite this 6th edition of a standard text.

British Medical Bulletin, Vol. 16, No. 3

Edited by F. G. Young, pp. 175-264, The British Council, September, 1960.

A symposium on the elusiveness, importance, and subtlety of action of insulin which includes one paper by the drug's co-founder, C. H. Best.

Synopsis of Pathology, 5th Ed.

By W. A. D. Anderson, M.A., M.D., F.A.C.P., F.C.A.P., 879 pp., $9.25, The C. V. Mosby Co., 1960.

Handy pocket sized compendium, now in its eighth year. The skin section is largely copied, sometimes inexactly, from Allen. The other portions have more merit.

The Organization of Psychiatric Care and Psychiatric Research in the Union of Soviet Socialist Republics, Vol. 84, Art. 4

By Nathan S. Kline, 97 pp., $3.00, The New York Academy of Sciences, 1960.

How they do it in Russia: well, on the whole.

★Physician's Handbook, 11th Ed.

By Marcus Krupp, M.D., N. J. Sweet, M.D., Ernest Jawetz, Ph.D., M.D., and Charles Armstrong, M.D., 547 pp., $3.50, Lange Medical Publications, 1960.

The same compact, invaluable, practical pocket reference work plus new chapters on Emergency Medical Examination and Chemical Analysis of Blood and Body Fluids.

The Thyroid-Vitamin Approach to Cholesterol Atheromatosis and Chronic Disease

By Murray Israel, M.D., 132 pp., $1.00, Vascular Research Foundation, N. Y., 1960.

If masked hypothyroidism promotes arteriosclerosis, this is an important book.

★The Office Assistant in Medical Practice

By Portia M. Frederick and Carol Towner (second edition), 407 pp., $5.25, W. B. Saunders, 1960.

This book could pay for itself a thousand times over in training a new—or polishing an experienced—office assistant. A doctor could learn from it himself.

The Surgical Clinics of North America, Vol. 40, No. 3

Pp. 575-859, W. B. Saunders Co., June, 1960.

A Lahey Clinic number on surgical technique.

The Surgical Clinics of North America, Vol. 40, No. 4

Pp. 861-1127, W. B. Saunders Co., August, 1960.

Two symposia, one on the surgical problems of the aged and the other on the surgical problems of infancy to the teen age, with an additional article on the significance of the transversalis and subserosal fasciae in surgery.

The Medical Clinics of North America, Vol. 44, No. 3

Thomas P. Almy, M.D., Guest Editor, pp. 605-859, W. B. Saunders Co., May, 1960.

A summary of the more common opportunities for better care in disease of the liver, pancreas, and biliary tract afforded by the scientific progress of recent years.

The Medical Clinics of North America, Vol. 44, No. 4

Pp. 861-1136, W. B. Saunders Co., July, 1960.

A Mayo Clinic number on common neurologic problems.

Clinical Obstetrics and Gynecology, Vol. 3, No. 2

Edited by Ernest W. Page, M.D., and Charles S. Stevenson, M.D., pp 269-536, Paul B. Hoeber, Inc., June, 1960.

Symposiums on "Physiology of Pregnancy" and "Endometriosis." The latter includes a chapter on sterility and fertility in women with pelvic endometriosis.

Pediatric Clinics of North America, Vol. 7, No. 2

Vincent C. Kelley, M.D., Consulting Editor, pp. 233-468, W. B. Saunders Co., May, 1960.

Authoritative evaluations of current concepts concerning a few subjects of general interest and importance relating to recent clinical advances.

Pediatric Clinics of North America, Vol. 7, No. 3

Meyer A. Perlstein, M.D., Consulting Editor, pp. 471-796, W. B. Saunders Co., August, 1960.

The newer aspects of neuropediatrics are covered at a clinical level.

(Continued on page 188)

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BOOK REVIEWS

(Continued from page 186)

★A Primer of Electrocardiography, 4th Ed.
By George E. Burch, F.A.C.P., and Travis Winsor, F.A.C.P., 293 pp., $5.00, Lea & Febiger, 1960.

Fourth edition in 15 years of one of the better primers of electrocardiography—which speaks for itself.

A Dictionary for Medical Secretaries
By Isabel Alice Stanton, 175 pp., $6.50, Chas. C. Thomas, 1960.

Streamlined, practical, handy reference work for secretaries. Hard to tell whether yours would find it adequate.

The Metabolism of Oral Tissues, Vol. 85, Art. 1
Edited by Otto V. St. Whitelock, pp. 499, $4.50, The New York Academy of Sciences, 1960.

Dentists, otolaryngologists, and dermatologists would find this interesting.

Professional School Psychology
Edited by Monroe G. Gottsegan, Ph.D., and Gloria B. Gottsegen, M.A., 292 pp., $7.75, Grune & Stratton, 1960.

Useful reference if you have a problem in this area. Pretty specialized.

Psychoanalysis and Human Values, Vol. 3
Edited by Jules H. Masserman, M.D., 377 pp., $11.00, Grune & Stratton, 1960.

This is for psychiatrists—and not all of them.

Antibiotics Annual 1959-1960
Edited by Henry Welch, Ph.D., and Félix Martí-Ibáñez, M.D., 1,034 pp., $15.00, Antibiotica, Inc., 1960.

The facts back of the advertisements—for those with time enough to go this deep.

Psychotherapists in Action
By Hans H. Strupp, 338 pp., $8.75, Grune & Stratton, Inc., 1960.

A novel and instructive analysis of psychotherapy, its techniques. For psychiatrists.

COUNTY SOCIETY REPORTS

(Continued from page 174)

With regard to the 50¢ charge for injections, they have tried to show us that a vast majority of states do not charge for injections except for the drugs, and they have proposed to drop this 50¢ charge for injections. Mr. Kennedy stated that the committee has not really gone into the x-ray and pathology section. The committee wants to follow the same procedure as with HMSA—print no fee schedule and let the doctors charge the going rate. Workmen's Compensation however was very reluctant to accept this. As it now stands if they won't accept the no fee schedule and pay the going rate, then we will ask for a $5.00 conversion factor. The Committee hopes the membership will allow the Board of Gov-

(Continued on page 190)

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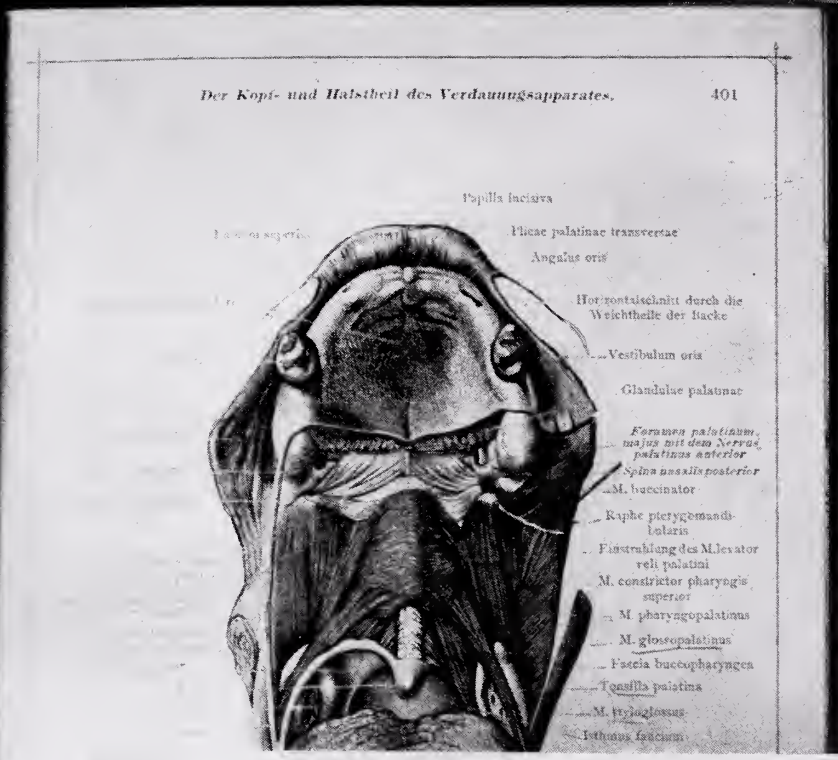
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B.G. 9-year-old, white male. First seen Aug. 11, 1959 with acute tonsillitis. Illness of 3 days' duration. Beta hemolytic streptococcus extremely sensitive to SYNCILLIN cultured from the throat. Patient started on SYNCILLIN – 250 mg. q.i.d. After 5 days, the infection appeared cured and the antibiotic was discontinued. No subjective or objective evidence of side reactions.

COUNTY SOCIETY REPORTS

(Continued from page 188)

ernors to authorize the circulating of the new fee schedule to the membership for approval by mail ballot.

A discussion followed during which Dr. Chinn asked, "If the Workmen's Compensation Bureau accepts the HMSA Surgical Fee Schedule, will they increase this fee schedule if HMSA decides to increase theirs?" Dr. Cushnie stated that he had asked Mr. Douglas of Workmen's Compensation this very question and he was informed by him that if the HMSA's fee schedule is revised upward to the Relative Value Schedule, Workmen's Compensation will renegotiate its fee schedule when the time comes.

ACTION:

It was moved by Dr. Freeman that the Society authorize the Board of Governors to circulate the membership with the fee schedule that is finally negotiated upon and if approved by the Society by mail ballot, that the schedule be adopted. The motion was seconded by Dr. Richardson and was carried.

HMSA Contract:

The Medical Care Plans Committee's recommendations with regard to the HMSA contract were brought up for discussion. Included in the discussion was a more recent report of the Medical Care Plans Committee meeting held June 14 which was circulated at the meeting. The report stated that Recommendation I and II were approved by the Board of Governors, however, the Board took no action on Recommendation III, only on specific thinkings of the committee.

Dr. Berk reviewed the recommendations as submitted by the Committee beginning with Recommendation which concerned increases in the medical benefits. H stated that the Major Medical Rider would take care o most of psychiatric hospitalization and care. With re gard to payment of anesthesiologists, the fees have bee raised from $10.00 to $15.00 plus $3.75 for each add. tional 15 minutes. With regard to increasing medica benefits for intensive medical care of a critical case i the hospital as listed in the recommendation, Dr. Ber stated that these were the things that five internists fel should be raised.

In the matter of additional consultation fees, it wa mentioned that one consultation is now allowed in case where the patient is listed as seriously ill in the hospita It was felt however that in certain cases such as traffi accidents where the patient has multiple injuries an requires the attention of several different specialists, mor than one consultation should be honored and that thi matter should be referred back to the Fee Adjustmen Committee for study. Dr. Faus agreed that in traffi cases more than one consultation per specialty shoul be allowed and stated that he would be glad to recom mend this to the HMSA.

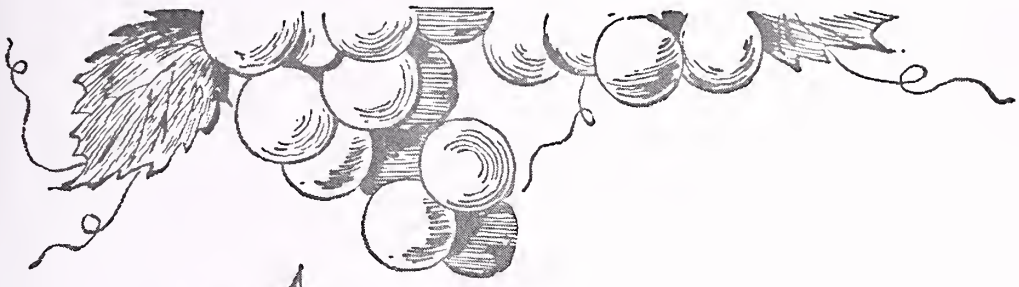
ACTION:

It was moved by Dr. Berk and seconded that Recommendation I re medical benefits as spelled out be adopted by the Honolulu County Medical Society. The motion was passed.

Dr. Nishigaya asked how much the above increase will cost the plan and whether this will raise the pre miums. He was informed by Dr. Berk that the cost o this increase would be approximately $110,000 and tha

(Continued on page 194)







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*Floore, F. B.: Wine is Fine for Hospital Cookery, Mod. Hosp. 94:134 (June) 1960.



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extra
antibiotic
activity

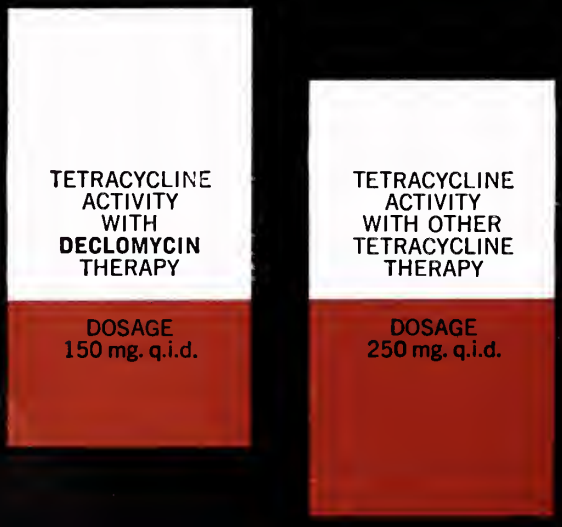
DEC

attains activity levels promptly

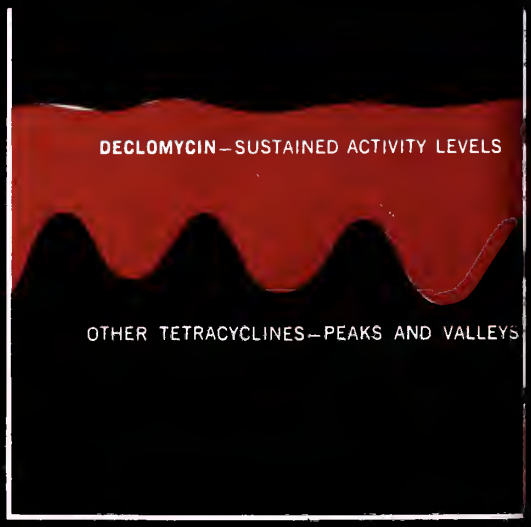
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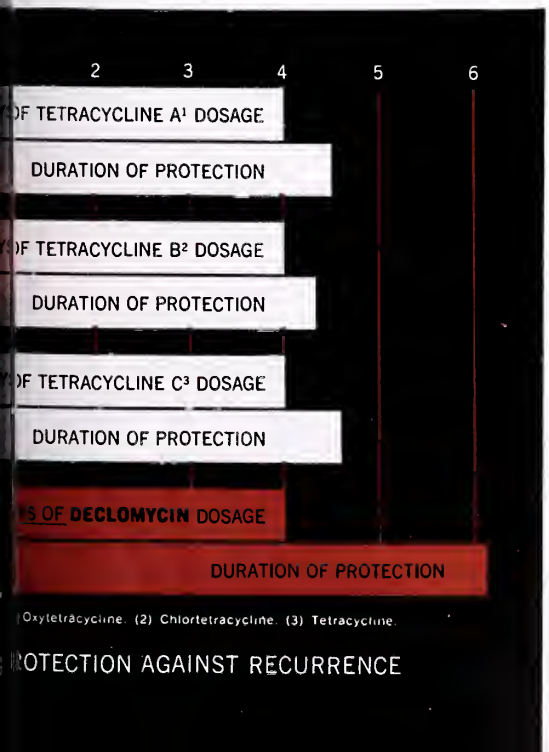
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COUNTY SOCIETY REPORTS

(Continued from page 190)

HMSA thinks they can do this without an increase to their premiums.

Some discussion was held on the anesthesiologists' fees with comments made by Drs. Chock, Schneider, and Johnsen. It was their feeling that the anesthesiologist's fees should not be set according to the surgical fee schedule as suggested by Dr. Cushnie as they felt that the surgical fee schedule was too low and that they wished to make their own recommendations concerning fees.

A discussion of Recommendation II was tied in with Recommendation III. Dr. Berk discussed the committee's recommendations for effecting a plan to control abuse and over-usage which they felt cost HMSA 10% to 25% and if proved to be effective would mean a savings of over $500,000 a year. This saving would offset any increase of premiums when the surgical fee schedule is raised to a full Relative Value Schedule with a $4.50 conversion factor by January 1, 1960, as recommended by the committee. Dr. Berk stated that the committee is not entirely happy over what they have come up with yet and there are still many loopholes. As for the individual contracts, he stated that there are still many physicians who are opposed to it. He asked the membership to give this whole matter some very serious thought and stated that the committee is open to suggestions from the membership and would welcome any thoughts on something that would be workable for both the Society and the HMSA.

ACTION:

Dr. Chinn moved that the Society accept Recommendation II which stated, "that the surgical fee schedule of HMSA be raised to the full Relative Value Schedule (4.50 conversion factor) effective January 1, 1961. The motion was seconded.

Further discussion followed. Dr. Nishigaya stated that before we go ahead and say we want 4.50 conversion factor we have to show HMSA that we can effect a saving first. Otherwise, the only recourse HMSA has is to raise the premium, which would make them noncompetitive.

Dr. Caver stated with regard to the 4.50 fee schedule that before we go ahead and put this into effect that the surgeons who do the surgery have to prove to us first that these are the fees that are being charged. As it seems now the practice is to accept what the patient's insurance can pay. It was Dr. Caver's feeling that since the details have yet to be worked out, this matter requires further study by the committee.

ACTION:

Dr. Caver moved to table Dr. Chinn's motion to accept Recommendation II to allow further study on this matter. The motion to table was seconded by Dr. R. Nishijima. The motion to table was carried by a vote of 58 to 44.

Dr. Berk stated that there was no effort on the pa of the committee to show any harrassment to the no participating physician but to only those non-participa ing physicians who are not okayed by the Medical Cor mittee. He reiterated that all of the committee's ide was just in the thinking stage and that the discussion t night was for the purpose of getting the thoughts the membership on this matter.

ACTION:

Dr. Ando stated that since tonight's discussion was for the purpose of searching out ideas he would like to move that we recommit Recommendation III and ask the committee to investigate the recommendation further, possibly through hearings, and report back to a subsequent meeting. The motion was seconded and was carried.

In conclusion, Dr. Pang stated that Dr. Berk and h committee did a commendable job and thanked Dr. Be for his excellent presentation. A round of applause l the membership was given in behalf of the Medical Ca Plans Committee.

* * *

The Honolulu County Medical Society met in Mab Smyth Auditorium on Tuesday, September 6, 1960 7:30 P.M. Approximately 135 persons were present. film by the Honolulu Community Chest was shown.

A joint meeting of the Hawaii Bar Association a the Honolulu County Medical Society was held to di cuss "Problems of Medical-Legal Testimony." A pan of three doctors and three attorneys discussed "Referr of patients by attorneys," "Renumeration for medic legal testimony," and "Doctor-patient relationship court." A question and answer period followed the pan presentation. Moderator was Daniel H. Case.

On "Drugs for Dooley," Dr. Pang requested Socie members to bring the drugs to the Society office sin Ken's Delivery Service went out of business.

Medical Research Program:

Dr. C. V. Caver reported a letter from the local Canc

(Continued on page 196)

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Swartz, H., "Clinical Evoluation of o New Drug (Algic) in the Symptomatic Therapy of Perennial Allergic Coryza," Current Theropeutic Reseorch, 2 : 1960.

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COUNTY SOCIETY REPORTS

(Continued from page 194)

Society requesting the Medical Society to oppose th inclusion of Medical Research Program of the Nationa Fund for Medical Education in the Honolulu Communit Chest Fund Drive. This matter was referred to th Public Service Committee which met once with th representatives of the local Cancer Society and onc with the Honolulu Community Chest. Dr. Caver state that since the Board of Governors is meeting in th third week of September and the drive is about to begir he was bringing the matter to the floor. Dr. Caver the briefly covered the highlights of his committee's findings

ACTION:

A motion that the Honolulu County Medical Society inform the Honolulu Community Chest of its opposition to the inclusion of the Medical Research Program of the National Fund for Medical Education in the Fund Drive was made by Dr. C. V. Caver, seconded and unanimously passed.

Bylaws:

Mr. Kennedy reported that the incorporation of th Society and the granting of statehood to Hawaii ha necessitated some technical changes in the Bylaws. Be sides these changes numerous grammatical changes hav been made, therefore, rather than taking each chang individually, the entire Bylaws were circulated for ap proval.

Dr. Pang pointed out that according to the amend ment procedures, the proposed changes must be read a a meeting prior to the meeting in which final action i to be taken and that a copy of the proposed change be circulated 10 days prior to the meeting in which fina action is to be taken.

ACTION:

A motion that the Bylaws as circulated be considered read throughout was made by Dr. Pershing Lo, seconded and passed.

O. D. PINKERTON, M.D.
Secretary

Kauai

The meeting of the Kauai County Medical Society was held at the Kauai Inn on May 3, 1960. The Hawai Medical Service Association was the host for the dinne after which the regular meeting was held.

The members of the Hawaii Medical Service Associa tion present were Mr. Veltmann, Dr. Faus, Mrs. Inouye Mr. Oliphant, Dr. Sakimoto, and Mr. Yuen.

Mr. Oliphant gave a report of the activity of HMSA for 1959.

Dr. Sakimoto said that State Employees Medical Plan will surely follow the Federal Employees Plan. He sai that the problem of fees charged by young specialists i Honolulu was a handicap to HMSA, and that he ha attempted to discourage these demands. Another diffi culty of HMSA is the rising cost of hospital care. H stated that the increase will be about $2.00 to $2.50 day beginning July 1, 1960.

Dr. Faus, in his remarks, stressed that he welcome discussion with physicians at any time they felt that th fee schedule was unfair. Mr. Veltmann discussed th Four Plans offered under the Federal Employees Pro gram. Mr. Yuen pointed out that there was a differenc

(Continued on page 198)

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COUNTY SOCIETY REPORTS

(Continued from page 196)

between Blue Shield and the HMSA plan in the Federal Employees Program.

Dr. Wilson was invited to speak to us at a special meeting on May 23 through the invitation of Dr. Kim.

The scientific part of the program consisted of a film of the "Report of the Dallas Clinical Meeting."

* * *

A special meeting of the Kauai County Medical Society was held at the Wilcox Memorial Hospital library on May 23, 1960, at 8:00 P.M.

The speaker of the evening, Dr. Julius Lane Wilson, chose as his subject, "Pediatric Tuberculosis."

* * *

The regular meeting of the Kauai County Medical Society was held at Wilcox Memorial Hospital library on June 7, 1960, at 7:30 P.M.

A letter from the Hawaii Visitors Bureau was read about the overdue subscription. Dr. Boido stated that last year it was decided that the contribution to the Bureau would be left to the individual doctor and that the Bureau had been so informed. Since we received the letter this year again, it was moved that the secretary write the Hawaii Visitors Bureau again about the decision made last year.

It was noted that the two reports of the Medical Care Plans Committee covering negotiations with Hawaii Medical Service Association were circulated by mail to the members this past month.

Dr. Cockett, as a member of the Medical Examining Board, reported on the subject of the last board meeting.

It was moved that there were no objections from the members of the Kauai County Medical Society to Dr. Brennecke, as a member of the State Board of Health from Kauai, writing items of interest in the Garden Island Newspaper encountered during the meetings of the Board of Health.

The business meeting was followed by an audio digest "Symposium on Survey Current Concepts in Modern Obstetrics."

* * *

The regular meeting of the Kauai County Medical Society was held at the Wilcox Memorial Hospital library on July 5, 1960, at 7:30 P.M.

Dr. Kim submitted a sample of the medical information form for referrals to Rehabilitation Unlimited Kauai for comments and suggestions. Dr. Kim volunteered to arrange a program for the August meeting on "Rehabilitation Unlimited Kauai."

Dr. J. T. Wang of Honolulu gave a talk on "Isotopes."

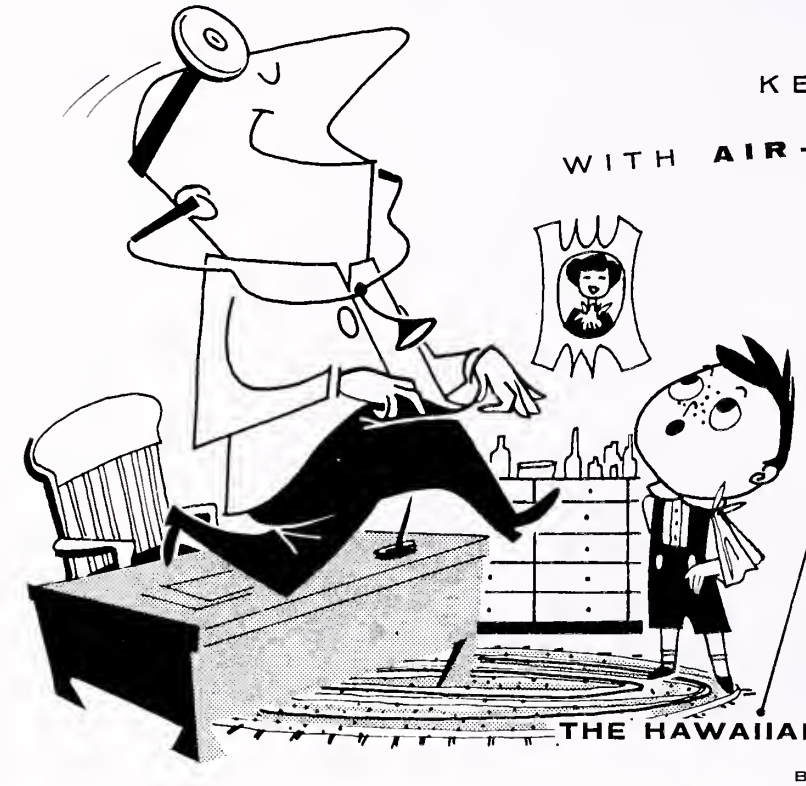
The membership was of the opinion that the Society could not intervene in the administration of the Board of Supervisors of County of Kauai, in behalf of the Department of Mental Hygiene, in allocating or renting space to a state organization.

* * *

The regular meeting of the Kauai County Medical Society did not have a quorum when it met on August 2, 1960, at the R. U. K. Workshop at Wailua, across from the Coco Palms Hotel. The doctors present were Wade, Zandee, Boyden, Kim, Fujii, and Brennecke.

The business part of the meeting was held from 7:30 to 8:30 P.M. The members present instructed the Secretary to invite Mr. Anthony Baptiste, or his representative, to the next meeting, September 6, to decide the

(Continued on page 202)

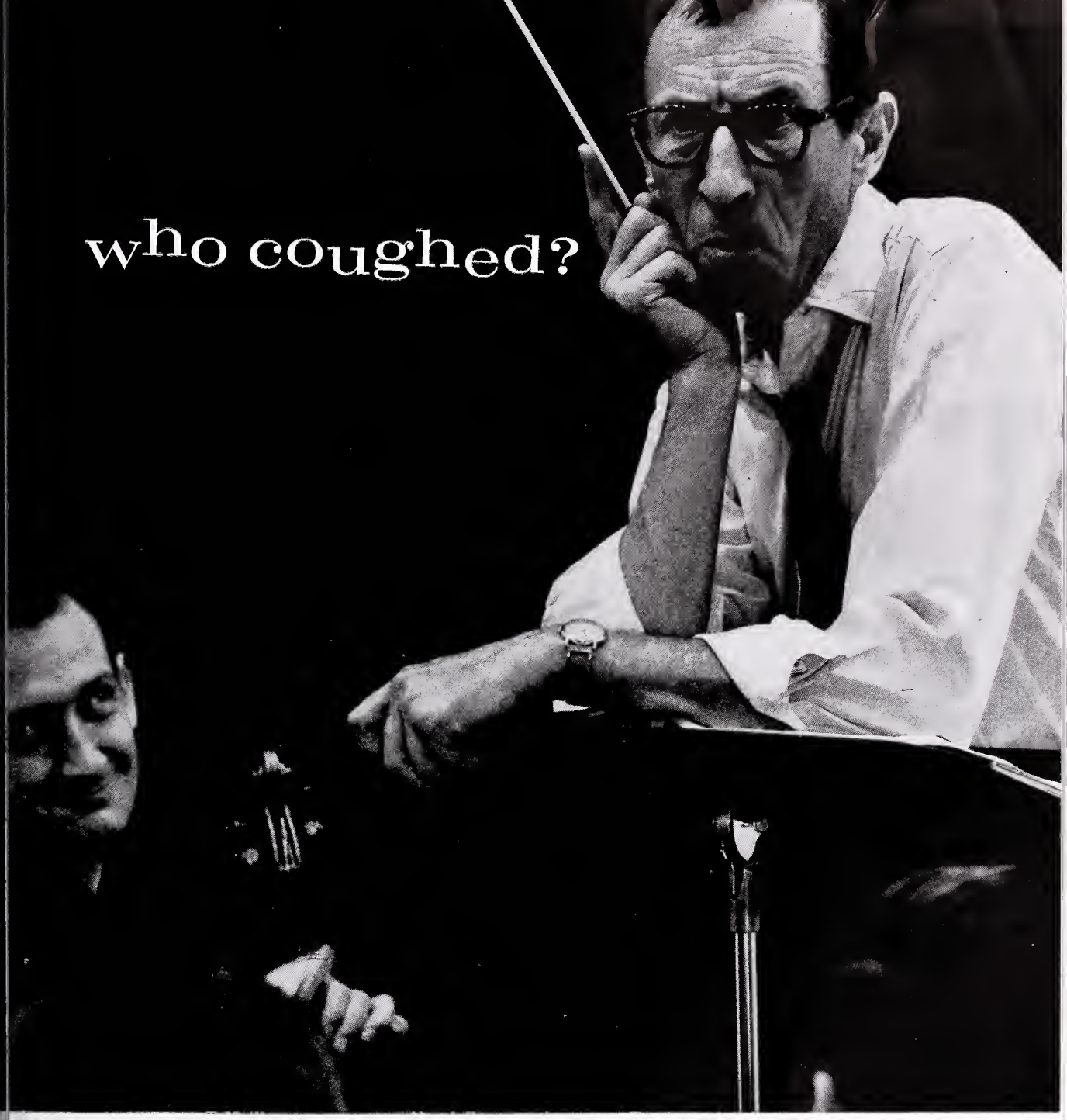


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References: 1. Ford, R. V., Cur. Therap. Res., 2:51, 1960. 2. Pitts, R. F., Am. J. Med., 24:745, 1958.

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COUNTY SOCIETY REPORTS

(Continued from page 198)

responsibility of the financial obligation of the medical care of the County Pensioners by the physicians of Kauai. It was pointed out that Dr. Robert Worth was in the process of making an arrangement with the County to pay on a fee for service basis, as is done in all the counties of the State except Kauai, when his tour of duty ended on this Island. To date nothing further has occurred.

At 8:30 P.M. the Society became the guest of the R. U. K. staff and officers. Those present were Mr. Van Dresser, President of the organization; David Murata, Occupational Therapist at the workshop; Masa Fujita, Director of Vocational Rehabilitation; Miss Ruth Smith, Psychologist and Admissions Committee Chairman; Miss Lou Huntley, Occupational Therapist and Chairman of Executive Committee; and Mrs. Stephen Au of the Bureau of Sight Conservation. Each spoke a few minutes. The following is a brief resume of the information presented:

The program of R. U. K. took eight years to develop. The Kauai Tuberculosis Association started it. The building, now debt free, was paid for by the Tuberculosis Association, Heart Association, Cancer Society, plus Federal and State funds. The land is leased from the State on an annual rental basis. The Tuberculosis Association has been the main contributor in establishing the facilities and in carrying the current costs.

Mr. Fujita stated that the agencies on Kauai can use R. U. K. to train handicapped people to return them to useful work.

Mr. Murata explained that the organization was able to: (1) explore and evaluate an individual as to his ability to return to work, and (2) train disabled people when these people cannot undertake this themselves.

Mr. Van Dresser asked the doctors for their opinion as to how to make better use of the facilities of this unit. One of the members of the Society stated that he believed that the only way to make it effective is to place Dr. Shepard at the head of all rehabilitation facilities in the State, so that whether for physical rehabilitation or for vocational rehabilitation, there is a concerted effort. Another doctor concurred in the belief that a centralized planning body from the State was better, as is being done in some of the other medical fields in the State, in order to avoid cross purposes and efforts.

* * *

The regular meeting of the Kauai County Medical Society was held at the Wilcox Memorial Hospital Library on September 6, 1960.

Dr. Kim asked the membership's opinion about the "Diabetes Detection Drive" for this year. It was moved and seconded that Dr. Kim inform the public that the doctors' offices and public health centers will be the detection centers.

The secretary read a letter addressed to Mr. Anthony C. Baptiste, Chairman of the Board of Supervisors,

(Continued on page 206)

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One outstanding advantage of triamcinolone is that it rarely produces edema and sodium retention.[1,2]

The clinical importance of this property cannot be overemphasized in treating certain types of patients. McGavack and associates[3] have reported the beneficial results with ARISTOCORT in patients with existing or impending cardiac failure, and those with obesity associated with lymphedema. Triamcinolone, in contrast to most other steroids, is not contraindicated in the presence of edema or impending cardiac decompensation.[3]

Hollander[1] points out the superiority of triamcinolone in not causing mental stimulation, increased appetite and weight gain, compared to other steroids which produce these effects in varying degrees. And McGavack,[2] in a comparative tabulation of steroid side effects, indicates that triamcinolone does not produce the increased appetite, insomnia, and psychic disturbances associated with other newer steroids.

ARISTOCORT can thus be advantageous for patients requiring corticosteroids whose appetites should not be stimulated, and for those who are already overweight or should not gain weight. Likewise, ARISTOCORT is suitable for the many patients with emotional and nervous disorders who should not be subjected to psychic stimulation. Furthermore, ARISTOCORT Triamcinolone, in effective doses, showed a low incidence of side reactions and is a steroid of choice for treating the older patient in whom salt and water retention may cause serious damage.[2]

References: 1. Hollander, J. L.: *J.A.M.A.* 172:306 (Jan. 23) 1960. 2. McGavack, T. H.: *Nebraska M. J.* 44:377 (Aug.) 1959. 3. McGavack, T. H.; Kao, K. Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958.

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. Dosage should be individualized and kept at the lowest level needed to control symptoms. It should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

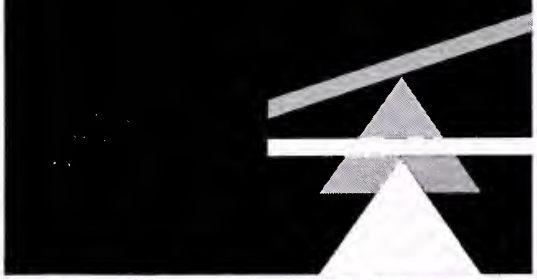
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on the pathogenesis of pyelonephritis:

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References: 1. Schreiner, G. E.: A.M.A. Arch. Int. M. 102:32, 1958. 2. Freedman, L. R., and Beeson, P. B.: Yale J. Biol. & Med. 30:406, 1958. 3. Rocha, H., et al.: Yale J. Biol. & Med. 30:341, 1958.

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COUNTY SOCIETY REPORTS

(Continued from page 202)

County of Kauai, about the financial responsibility of the County of Kauai pensioners. Mr. Anthony Baptiste, or his representative, did not appear at the meeting to discuss this problem. Nor did he reply to the letter sent by the Society.

At the end of the business meeting, the picture "For Laughing Out Loud" was shown.

MARVIN A. BRENNECKE, M.D.
Secretary

Maui

The meeting of the Maui County Medical Society was called to order November 24, 1959, at the Vineyard Chop Suey House. The meeting was called to order by the President, Dr. L. T. Kashiwa.

The following slate of officers for 1960 was presented by the nominating committee consisting of Drs. McArthur, Shimokawa, and St. Sure:

President.....Dr. A. Y. Wong
Vice President.....Dr. C. F. Moran
Secretary-Treasurer.....Dr. S. Ohata

It was moved by Dr. Shimokawa and seconded by Dr. Patterson that nomination be closed. Motion was passed unanimously. Dr. Sanders moved and Dr. Underwood seconded that a unanimous ballot be cast for the above slate. Motion was passed unanimously.

Dr. Patterson moved and Dr. McArthur seconded that the lay secretary be given $100 a year for her services. It was passed with one dissenting vote.

A. Y. WONG, M.D.
Secretary-Treasurer

* * *

A special dinner meeting of the Board of Governors was held at the Wailuku Hotel on January 7, 1960.

Guests present were: Dr. Toru Nishigaya, President of the Hawaii Medical Association, Mr. Joseph Veltmann, and Mrs. Louise Smith, of H.M.S.A.

Mr. Veltmann and Dr. Nishigaya discussed in detail Public Law 86-382, known as the Federal Employees Health Benefit Act of 1959, which provides for a government sponsored medical care program.

At 7:35 P.M. a special meeting of the Maui County Medical Society was held in the conference room of the Central Maui Memorial Hospital.

Dr. Toru Nishigaya presented his annual presidenti message. He announced that the Governor's Institute c Rehabilitation is scheduled for January 10-24, 196 that the same program will be presented on Maui c January 19-20, 1960, and urged each member to atten

He then discussed the workman's compensation f schedule. He reported that a committee consisting c the President of the H.M.S.A., a representative from th labor board, and a representative from the insuran company met to discuss this fee schedule. The Californ fee schedule was found to be reasonable and acceptabl It was acceptable provided the doctors appointed a con mittee to police the plan.

Mr. Veltmann discussed in detail the medical pla for Federal employees, which provides for a governmen sponsored medical care program to become effective Ju 1, 1960.

After much discussion, the following motion was ma by Dr. Burden: "We recommend that H.M.S.A. authorized to qualify under 4-b with removal of incon clause, however, we will concur with the decision the Honolulu County Medical Society." Motion w seconded by Dr. McArthur and passed unanimously.

Dr. Andrews requested a vote of confidence to reta Dr. Moran as hospital administrator. It was so move by Dr. Burden, seconded by Dr. Patterson, and passe

Dr. Tompkins invited the members of the Society f cocktails at his home at 6:00 P.M. on January 19, 196 before the meeting at Kula Sanatorium.

Dr. Iaconetti again brought up the question of wit holding doctors' names from newspaper articles. T secretary was again instructed to write a letter to t respective presses expressing the sentiment of the Societ

* * *

A regular meeting of the Maui County Medical S ciety was held on January 19, 1960, at the Kula Sa atorium.

Guests present were: Drs. David Kliewer, Bil Sowers, Leo Bernstein, Leon Lewis, David Frost, a Charles Hayman; Mrs. Seema Allen, Miss Edythe Larson, Mrs. Dorothy Thomas, Miss Clara Arrington Mr. Paul Pugh, Mr. Kenji Sagara, Miss Aiko Tatsun Miss Dorothy Longbotham, and Mr. Meiji Hirose.

A roast pig dinner was enjoyed by all. The readi of the minutes of the special meeting was dispens with.

The meeting was called to order at 8:15 P.M. President, Dr. A. Y. Wong, who gave a brief histo of the inception of the Governor's Institute on Rehab

(Continued on page 208)



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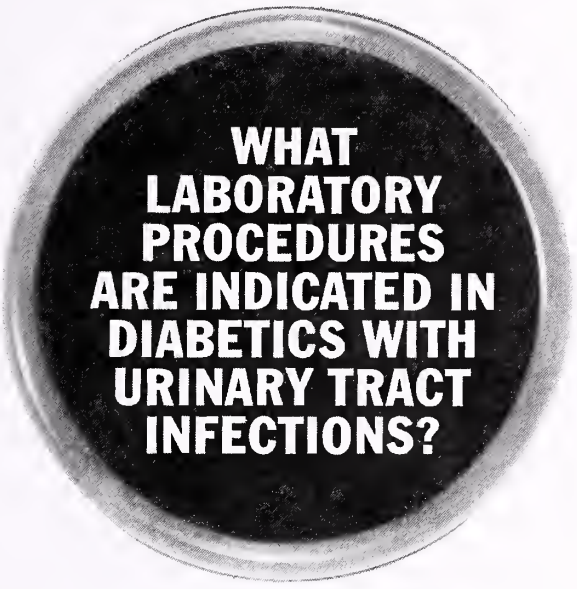
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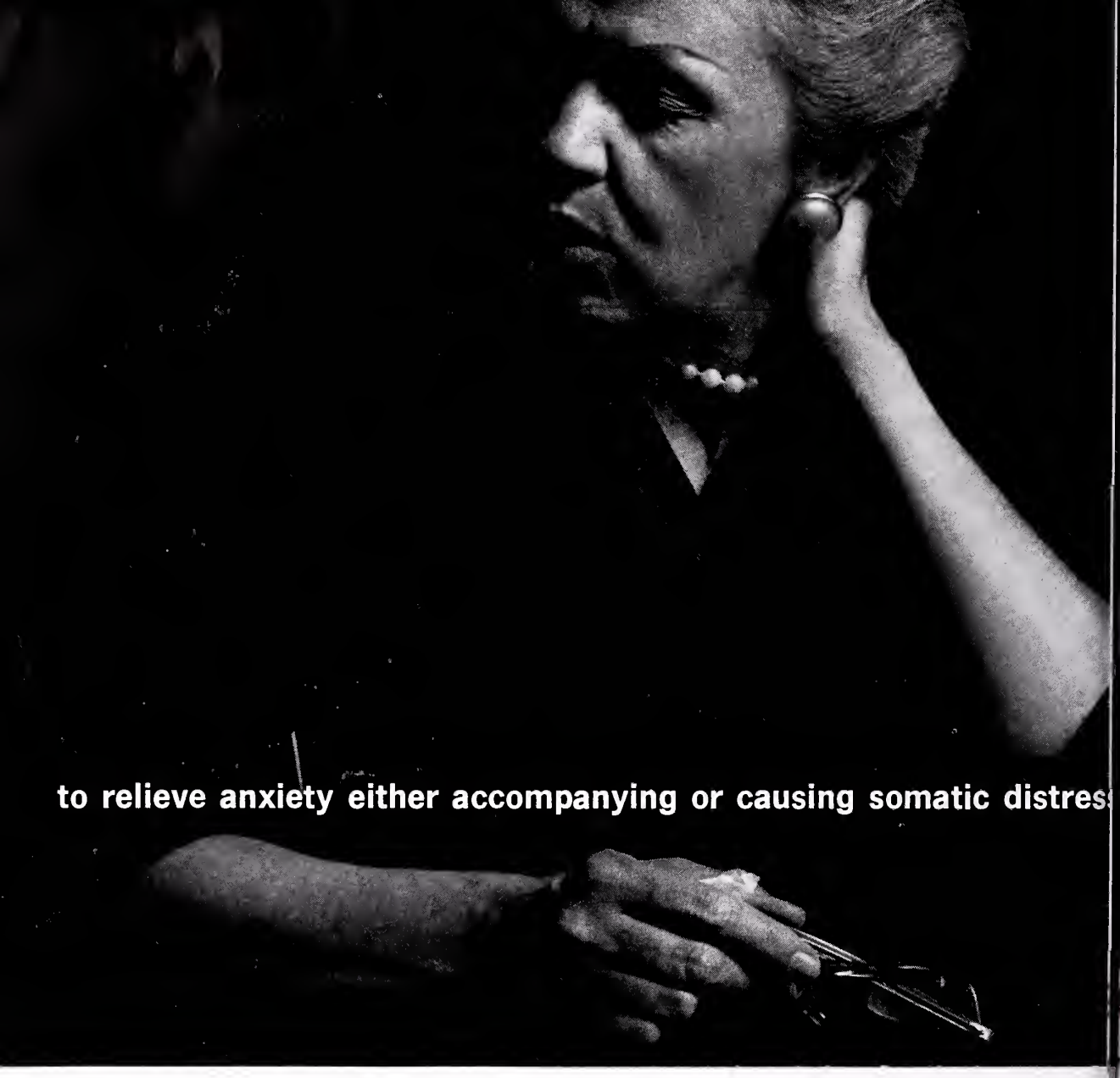
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1. Marx, F.J., in *Trifluoperazine: Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959, p. 89.
2. Winkelman, N.W., Jr.: *ibid.*, p. 78.

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HAWAII MEDICAL JOURNAL

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References: (1) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* 173:475, 1960. (2) Goslings, W. R. O., & Büchli, K.: *Arch. Int. Med.* 102:691, 1958. (3) Goodier, T. E. W., & Parry, W. R.: *Lancet* 1:356, 1959. (4) Fisher, M. W.: *Arch. Int. Med.* 105:413, 1960. (5) Petersdorf, R. G., *et al.*: *Arch. Int. Med.* 105:398, 1960. (6) Glas, W. W., in Symposium on Antibacterial Therapy, Michigan & Wayne County Aead. Gen. Pract., Detroit, September 12, 1959, p. 7. (7) Modarress, Y.; Ryan, R. J., & Francis, Sr. C. E: *J. M. Soc. New Jersey* 57:168, 1960. (8) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* 82:513, 1960.

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*Adapted from Bauer, Perry, & Kirby[1]

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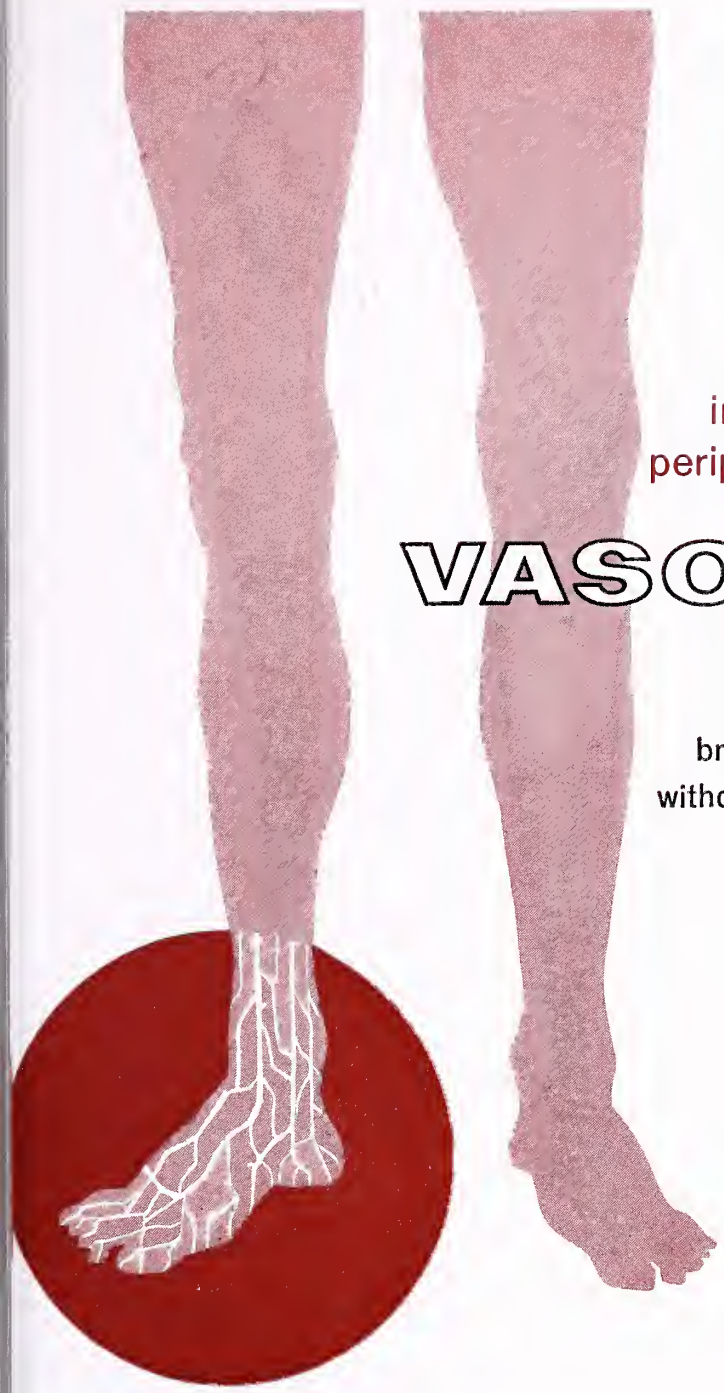
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references: (1) Samuels, S. S., and Shaftel, H. E.: Effects of Isoxsuprine Hydrochloride on Blood Sugar Levels and on Requirement for Insulin or for Tolbutamide in Normal Subjects and in Diabetic Patients, to be published. (2) Samuels, S. S., and Shaftel, H. E.: J.A.M.A. *171*:142-144 (Sept. 12) 1959. (3) Kaindl, F., *et al.*: Angiology *10*:185-192 (August) 1959. (4) Kraucher, G.: Prakt. Arzt *11*:325-329 (May) 1957. (5) Birkmayer, W., and Mentasti, M.: Wien. med. Wchnschr. *108*:395-396 (May 3) 1958. (6) Clarkson, I., and LePere, D.: Angiology *11*:190-192 (June) 1960. (7) Billiottet, J., and Ferrand, J.: Sem. méd. *34*:635-637 (May) 1958. (8) Singer, R.: Wien. med. Wchnschr. *107*:734-736 (Sept.) 1957.

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JANUARY-FEBRUARY, 1961

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Monday—12:30 p.m.—weekly luncheon—case reports
Thursday—8:30 a.m.—grand raunds
Friday—12:30 p.m.—4th Friday of each quarter beginning in January—staff luncheon and meeting

Kapiolani

Tuesday—12:30 p.m.—weekly—didactic program and luncheon
Tuesday—4:30 p.m.—3rd Tuesday of each month—ab.-gyn. statistics
Thursday—12:30 p.m.—2d Thursday af each month—Medical Executive Cammittee meeting and luncheon
Thursday—12:30 p.m.—3d Thursday of each month—staff meeting and luncheon

Kuakini

Tuesday—1:00 p.m.—2d Tuesday—medical conference and C.P.C.
Tuesday—4:30 p.m.—4th Tuesday—ab.-gyn. statistic conference
Friday—1:00 p.m.—1st, 3d, and 4th Fridays—surgical canference
Friday—1:00 p.m.—2d Friday—ob.-gyn. staff conference
Friday—5:15 p.m.—2d Friday—dinner and staff meeting

Queen's

Monday—12:30 p.m.—weekly ob.-gyn. conference
Tuesday—4:15 p.m.—weekly surgical conference
Tuesday—4:15 p.m.—last Tuesday of each month—EENT canference
Thursday—12:15 p.m.—1st Thursday of each month—pediatric conference
Thursday—8:00 a.m.—3d Thursday of each manth—psychiatric canference
Friday—12:30 p.m.—last Friday of each quarter—staff meeting and lunchean
Friday—4:15 p.m.—weekly medical conference

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Manday—12:30 p.m.—4th Monday—surgical meeting
Tuesday—12:30 p.m.—2d and 4th Tuesdays—medical meeting
Tuesday—3:30 p.m.—1st and 3d Tuesdays—pathology
Tuesday—12:30 p.m.—2d and 4th Tuesdays—x-ray conference
Wednesday—12:30 p.m.—1st Wednesday—pediatric meeting
Friday—7:00 a.m.—weekly—surgical grand rounds
Friday—1:00 p.m.—1st Friday—ob.-gyn. statistical meeting
Friday—12:30 p.m.—3d Friday—general practice meeting
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Friday—12:30 p.m.—3d Friday—quarterly beginning in March—general staff meeting

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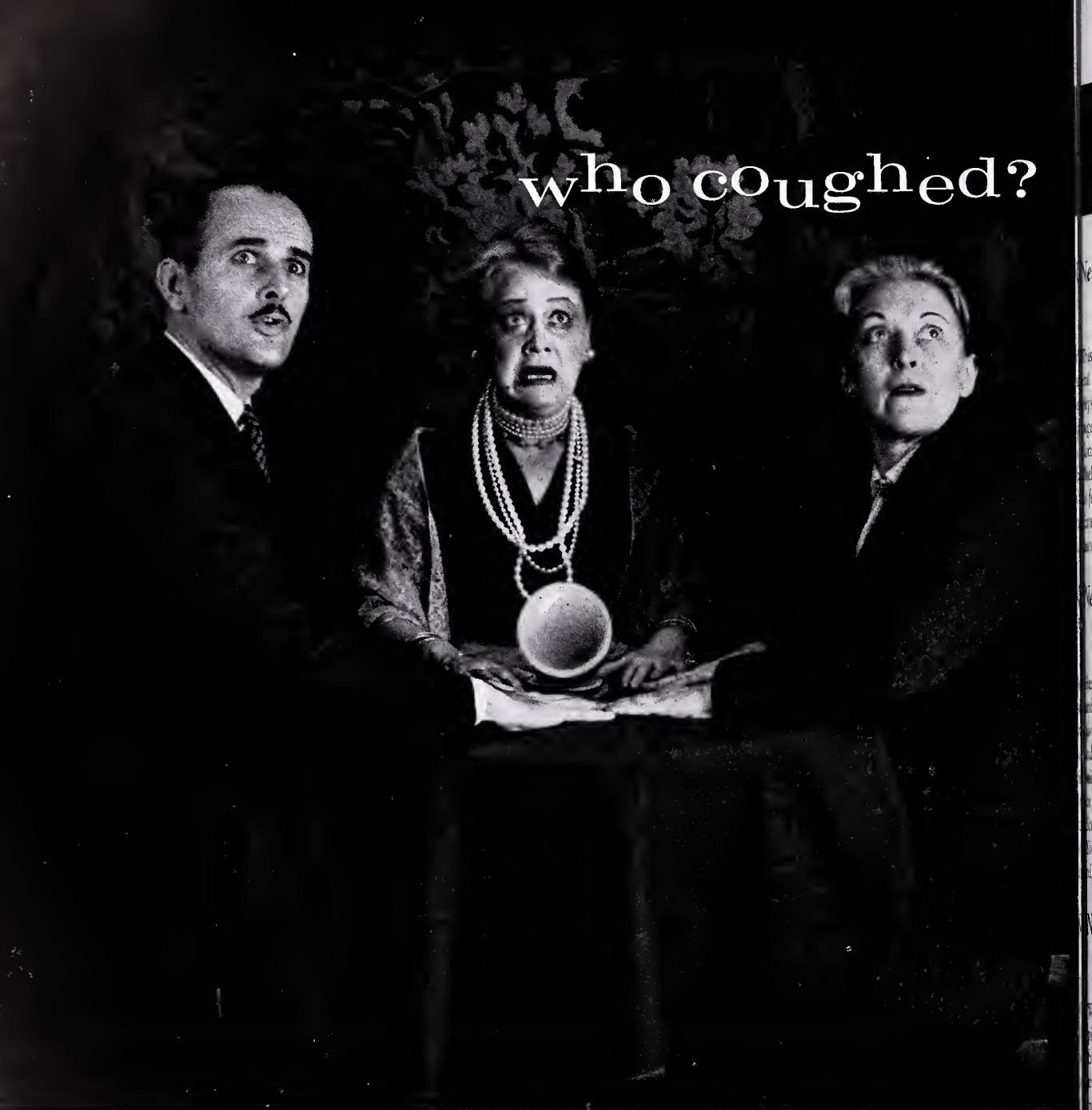
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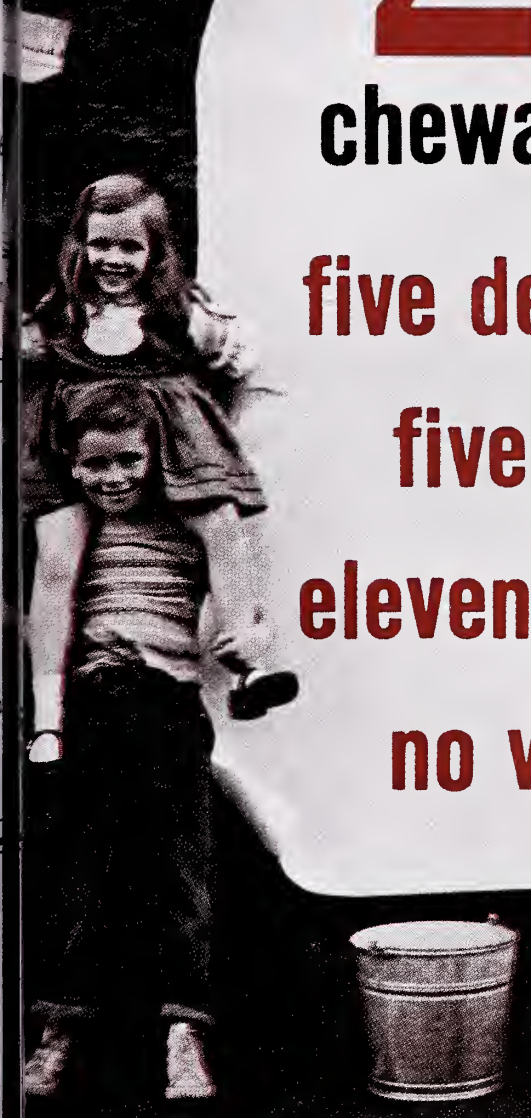
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References: 1. David, N. A.; Parter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

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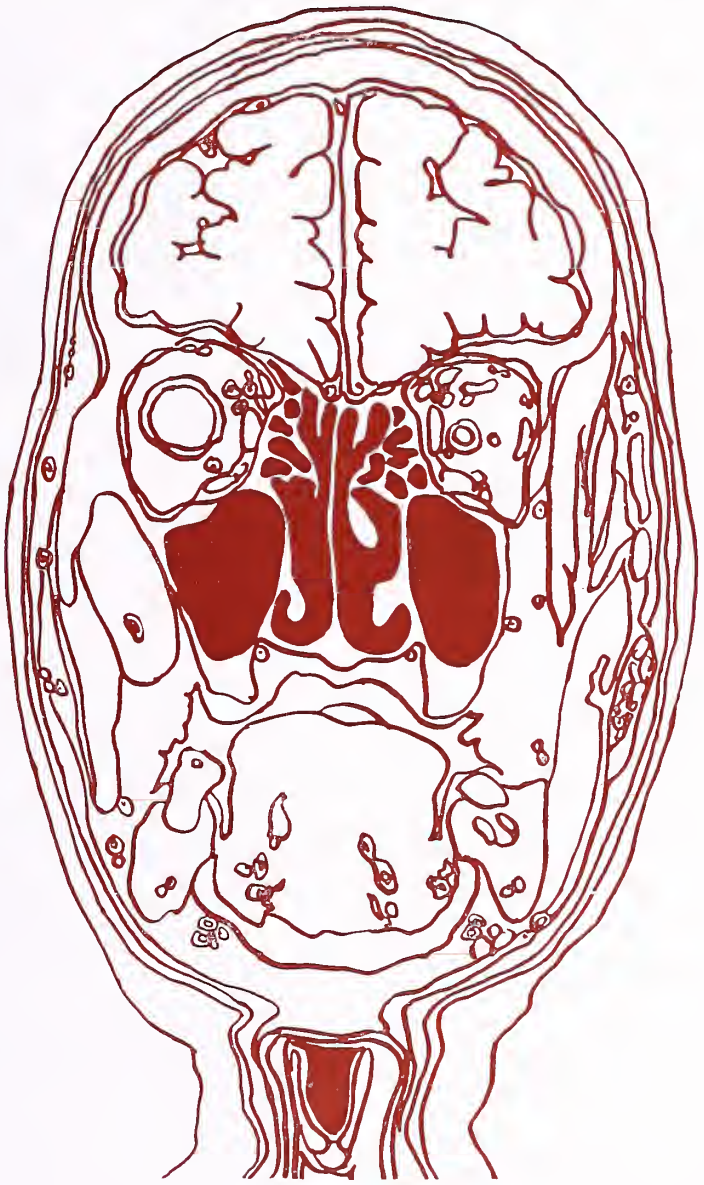
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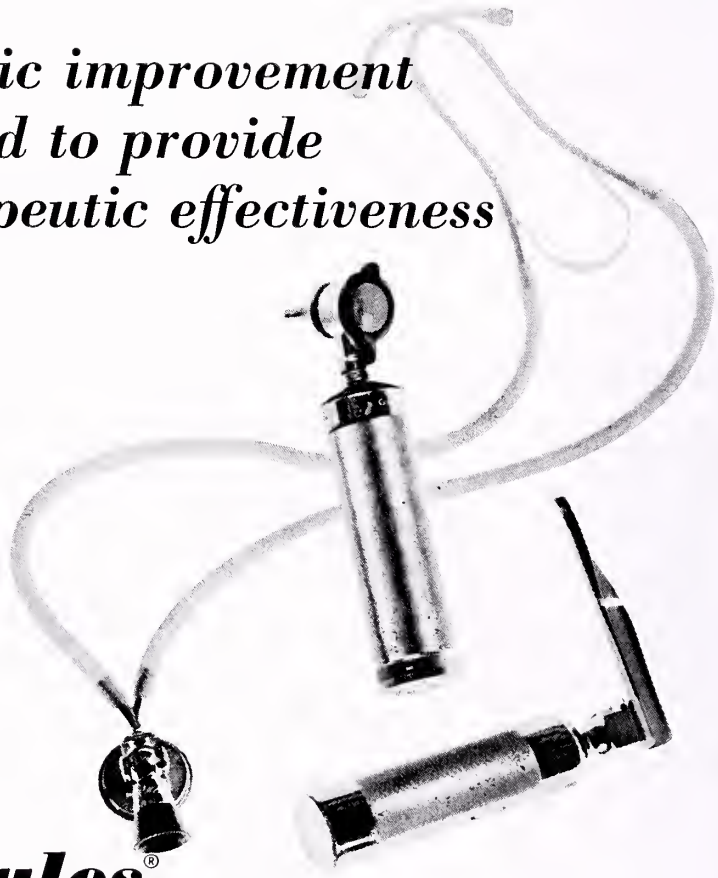
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1. Stephens, V. C., *et al.:* J. Am. Pharm. A. (Scient. Ed.), *48*:620, 1959.
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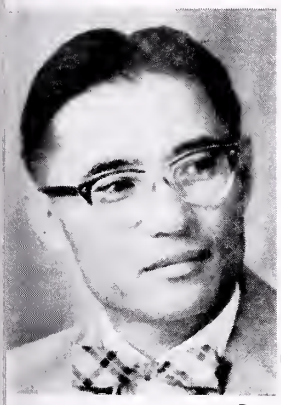
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Widely held beliefs, in medicine as elsewhere, "ain't necessarily so." Here's a close look at a few medical beliefs in Hawaii, by a hospital pathologist.

Some Disease Peculiarities in Hawaii

PAUL Y. TAMURA, M.D.,* Honolulu

OVER THE YEARS, physicians practicing in Hawaii have noted many disease peculiarities. These cover various phases of medicine such as existence or absence of certain diseases, and relative incidence of diseases among different ethnic groups. The geographic isolation of Hawaii, and the presence of an admixture of races, make Hawaii ideal for these observations.



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An inquiry among relatively few physicians, both specialists and nonspecialists, easily elicited quite a formidable list of medical "credos." I selected a few of the more popular ones, *all not necessarily true,* as a "springboard" for discussions.

"Hawaiians are more susceptible to infectious diseases than other racial groups."

The infectious disease status of Hawaii has undergone considerable change over the years. There was a time when these islands must have been a medical paradise, practically free of infectious diseases. With the "foreigners," in particular the sailors and laborers, different diseases such as leprosy, cholera, plague, smallpox, measles, tuberculosis, and syphilis were introduced. They ran their course and took a large toll of, in particular, the susceptible native Hawaiians.

Up to about a decade ago this susceptibility of Hawaiians to infectious diseases seemed to exist.[1] There is some doubt whether this is still true today, but it is difficult to determine this point conclusively because the incidence of infectious disease has decreased considerably by effective public health measures and effective medical therapy. Today, it appears that the morbidity and mortality due to infectious diseases in Hawaii are not unlike those of any large city in the United States.

In leprosy, about one-half of the 208 cases occurring in the ten years from 1949 to 1959 were in Hawaiians and part-Hawaiians, one-fourth in Filipinos, and the remaining distributed amongst the other races.[2] Most of the Filipino patients were born and reared in the Philippine Islands.[3] As compared with figures from the previous decade[1b] the incidences in these races do not appear to have changed much. However, there has been a very substantial decrease in the incidence of new cases of leprosy over the past ten years[2] with only 10 new cases last year as compared with 32 new cases in the year 1949 to 1950. The disease pattern has been altered considerably by therapy.[9] The mortality is low and today one hardly ever sees the former disfiguring, crippling, and destructive picture.[2]

In 1948, the mortality due to tuberculosis was comparatively high and two-fifths of deaths were in Hawaiians and Filipinos.[1a] Today the mortality is much lower. In recent figures based on Leahi Hospital admissions, the Hawaiians and part-Hawaiians do not have an abnormally high incidence in proportion to the population. In fact, only the Filipinos still seem to show an abnormally high incidence.[5]

"Certain mosquito borne diseases constitute a potential danger to Hawaii."

As potential vectors of disease the mosquitoes exist in Hawaii, but fortunately we do not have the Anopheles mosquito which could transmit malaria.[6] These agents of malaria have been successfully kept out through the combined efforts of the United States Public Health Service, State Board of Health, and the Board of Agriculture. However, we have Aedes and the Culex mosquitoes. These are capable of transmitting viral dis-

* From the Department of Laboratories, The Queen's Hospital, Honolulu, Hawaii.

[1] (a) Marks, R. H.: Some aspects of the tuberculosis problem in Hawaii, HAWAII M. J. 7:382 (May-June) 1948. (b) Chung-Hoon, E. K.: Hansen's Disease in Hawaii, 1939-1949, HAWAII M. J. 9:305 (May-June) 1950. (c) Berk, M. E., and Hartwell, A. S.: Five years of heart disease in Hawaii, HAWAII M. J. 8:177 (Jan.-Feb.) 1949. (d) Connor, A., and Yoshina, T.: Rheumatic fever in Hawaii, HAWAII M. J. 10:181 (Jan.-Feb.) 1951. (e) Lee, R. K.: Poliomyelitis, HAWAII M. J. 1:11 (Sept.) 1941.

[2] Chung-Hoon, E. K.: Personal communication.

[3] Chung-Hoon,[1b] *idem*,[2] *idem* and Hedgcock.[4]

[4] Chung-Hoon, E. K., and Hedgcock, G.: Racial aspects of leprosy and recent therapeutic advances, HAWAII M. J. 16:125 (Nov.-Dec.) 1956.

[5] Walker, H. H.: Personal communication.

[6] (a) Panel Discussion, May 5, 1944, Tropical disease dangers in Hawaii, HAWAII M. J. 4:9 (Sept.-Oct.) 1944. (b) Pemberton, C. E.: Insects and other arthropods of medical interest in Hawaii, HAWAII M. J. 2:191 (Mar.-Apr.) 1943.

eases such as yellow fever, equine encephalitis, St. Louis encephalitis, and Japanese B encephalitis. We have not had these as yet.

We don't encounter elephantiasis due to filariasis in Hawaii. Thus, we either do not know or we forget that there is filariasis among the Samoans in Laie, Oahu. This becomes apparent when these individuals are admitted to the hospitals and have routine blood smear examination. Since both the Aedes and the Culex are here, some have feared this situation as a real danger to Hawaii. However, filariasis has self-limiting features. In those that are sensitized, reinfection over a period of years is required to produce classical elephantiasis. In those that are not, the microfilaria don't seem to do much harm. It has been stated that microfilaria can be transfused without ill effects.[6a] To complete the life cycle, the filaria must have mosquitoes. Within the mosquito multiplication does not occur; a large number of microfilaria kills the vector; and with even a small number, the mosquito doesn't fly far. Reasonable mosquito control with average amount of clothing is felt to be sufficient to control this disease here.[7]

Most of us remember the epidemic of dengue fever in Honolulu in 1943, shortly after the commencement of the war. Aedes albopictus and aegypti are the vectors involved. This epidemic strikes periodically.[9] The previous episodes were in 1903 and another in 1912, when 60 per cent of the population were affected.[10]

"Fleas are the vectors for plague and endemic typhus. These diseases occur periodically on the islands of Hawaii and Maui."

Prior to 1943, an average of two cases of plague were seen each year on the islands of Hawaii and Maui.[12] However, no cases have been reported to the Board of Health since 1949.[13]

It is a bit surprising that typhus occurs only rarely. The organism of this disease has been demonstrated in the brains of local rats[14] and these rodents are difficult to control because rodent food, including the kiawe bean, is everywhere.[6a]

The rodents are involved in leptospirosis. This disease has been known to exist in the islands for some time.[15] Leptospirosis is most common on the island of Hawaii, particularly among the cane cutters in irrigated, rat infested areas.[16] It has been shown that the disease exists not only in rats but also in mongooses, dogs, and cats.[15c]

"Parasitic diseases: Human infestation severe enough to cause death is rare in Hawaii."

An array of flukes, round worms, and tapeworms have been introduced with animals from the United States and the Orient. To name a few we have Balantidium coli, Taenia solium, Trichinella spiralis, and Strongyloides stercoralis from swine, and Taenia saginata and Fasciola gigantica from cattle. The latter, a liver fluke, has also been demonstrated in horses and is believed also to exist in sheep and swine.[17] Human infestation results from contaminated water or vegetation, in particular, watercress.[18] Measures to eliminate watercress from the infested areas on Hawaii have been instituted.[19]

Beef tapeworm (Taenia saginata) disease occurs most commonly in Filipinos. Between 1942 and 1945 at The Queen's Hospital, 126 cases were encountered. Of these 110 were in Filipinos.[20] The incidence of trichinosis is also high in this race. It is believed that with a predominance of bachelors amongst Filipino men, inadequately cooked meat is consumed by these individuals.

An intestinal fluke called Stellantchasmus falcatus (closely related to Heterophes heterophyes) was acquired by eating raw mullet from Hauula and Punaluu area.[21] Recently, it has been pointed out that Paragonimus westermani could exist in the islands because the intermediate hosts (snails and crayfish) are present in the island waters.[22] The organisms, however, have not definitely been demonstrated as yet. Neither has a human infestation in a local resident been diagnosed.

The cone-nose "assassin" or "kissing" bug, Triatoma rubrofasciata,[23] is found on Oahu. Trypanosomes nonpathogenic to rats and mice occur in their gut. Theoretically, this species of cone-nosed bugs is capable of transmitting South American trypanosomiasis (Chagas' disease).[24]

[7] Panel Discussion.[6a] Babione.[8]
[8] Babione, R. N.: Mumu, HAWAII M. J. 5:69 (Nov.-Dec.) 1945.
[9] Beck, L. C.: Progress in internal medicine—dengue fever, HAWAII M. J. 2:311 (July-Aug.) 1943.
[10] Beck.[9] Editorial.[11]
[11] Editorial: Dengue fever, HAWAII M. J. 3:25 (Sept.-Oct.) 1943.
[12] Carter, C. L.: Bubonic plague on the island of Hawaii, HAWAII M. J. 2:296 (July-Aug.) 1943.
[13] Enright, J. R.: Personal communication.
[14] Alicata, J. E., and Breaks, V.: Typhus fever in Honolulu, HAWAII M. J. 2:59 (Nov.-Dec.) 1942.
[15] (a) Hoagland, R. J.; Harris, F. H.; and Chinen, S. S.: Leptospirosis (Weil's disease), HAWAII M. J. 2:131 (Jan.-Feb.) 1943. (b) Enright, J. R., and Fennel, E. A.: Weil's disease in Hawaii, Proc. 6th Pacific Science Cong. 5:337, 1939. (c) Alicata, J. E., and Breaks, V.: A survey of leptospirosis in Honolulu, HAWAII M. J. 2:137 (Jan.-Feb.) 1943. (d) Patterson, H. M.: Weil's disease: A report of thirty-seven cases, HAWAII M. J. 3:213 (May-June) 1944.
[16] Hoagland, and others,[15a] Patterson.[15d]
[17] Alicata, J. E.: Parasites and parasitic diseases of domestic animals in the Hawaiian islands, Pacific Sc. 1:69 (Apr.) 1947.
[18] (a) Alicata, J. E.: Human fascioliasis in the Hawaiian islands, HAWAII M. J. 12:196 (Jan.-Feb.) 1953. (b) Stemmermann, G. N.: Human infestation with Fasciola gigantica, Am. J. Path. 29:731 (July-Aug.) 1953. (c) *idem*: Human infestation with Fasciola gigantica, HAWAII M. J. 13:19 (Sept.-Oct.) 1953.
[19] Stemmermann, G. N.: Personal communication.
[20] Editorial (Price, A. S.): Beef tapeworm in Filipinos, HAWAII M. J. 5:334 (July-Aug.) 1946.
[21] Glover, M. A., and Alicata, J. E.: Case report: intestinal heterophyidiasis, HAWAII M. J. 16:636 (July-Aug.) 1957.
[22] Graumann, H.: Personal communication.
[23] Pemberton,[6b] Editorial.[24]
[24] Editorial (Bonnet, D. D.), HAWAII M. J. 5:88 (Nov.-Dec.) 1945.

Toxoplasmosis exists in Hawaii.[25] Men may acquire and recover from this disease without signs. In the pregnant woman, the organisms pass the placental barrier and reach the fetus to cause mischief—miscarriage, prematurity, or hydrocephalus. Stitt and Levine[25a] found high titers in dye tests of Sabin-Feldman in four of six children with chorioretinitis. Tilden[25b] reported a case in a Filipino infant which expired within 24 hours of delivery.

"Fungus diseases are common in Hawaii because of the mild climate."

Regarding fungus diseases, the superficial fungi here are not unlike those found elsewhere.[26] Microsporon Audouini has not been found here. The deep mycoses encountered in Hawaii include actinomycosis (which is frequent in cattle), nocardiosis, maduromycosis, sporotrichosis, cryptococcosis, and moniliasis.[27] Blastomycosis and chromoblastomycosis have not been reported. Cryptococcosis is encountered from time to time and, in the autopsy series from The Queen's Hospital in past five years, has been the cause of death in two instances. Infrequently at autopsy, a subpleural nodule containing this organism is discovered as an incidental finding. Histoplasmosis has been reported,[28] though the diagnosis in this case has since been seriously questioned. Coccidioidomycosis, when encountered, has invariably been in individuals from the southwestern United States. Deep mycoses cannot be considered common in Hawaii.

"The Filipinos have a high incidence of prematurity."

Statistics show that the oriental newborn tends to be small. Connor *et al.*[29] found that the Filipino had one-third and the Japanese had one-fourth of their births in the 2501-3000 gm group, which is just above the arbitrary dividing line (2500 gm) between prematurity and maturity. By contrast, the Caucasians had only one-fifth of their births in this category. The Orientals had one-fifth or less of their newborns in the 3501 to 4000 gm group while the Caucasians had one-fourth. Using the criterion of 2500 gm or less, Bennett and Louis[30] found the highest rate of prematurity in the Filipino (11.6%), Puerto Rican (10.2%), and Hawaiian (9.4%) groups, while other races had about 6.5% or less. However, many clinicians consider this criterion as being arbitrary and unreliable. They prefer to use other criteria such as period of gestation, or physical and physiologic evaluation of the newborn. Often the newborns are just treated as prematures because even with these criteria, the distinction cannot definitely be made.

"Erythroblastosis due to Rh negative is rare in the Oriental."

Rh negative Orientals are very uncommon. The Blood Bank of Hawaii found 23 in 2,348 Japanese and one in 330 Chinese. Two other studies showed an incidence of two in 150 among Japanese[31] and Chinese.[32] Erythroblastosis fetalis due to Rh factors is rare in Orientals. In the past year, the Blood Bank of Hawaii examined bloods of 86 Rh negative women and encountered 32 with Rh antibodies.[33] Of these, there were four Japanese women, three of whom were Rh negative and one Rh positive. There were two Chinese women in this group, one Rh negative and the other Rh positive. The Rh positives showed sensitization to a subtype of Rh. The total number of newborns from the entire group eventually receiving exchange transfusion was eight.

Cases of erythroblastosis due to ABO incompatibilities have been reported.[34] The majority of these cases have an O mother with an A or B infant. The mild form of ABO reaction in pregnancy is not uncommon. During the past year, nine ABO antibody titrations were performed by the Blood Bank of Hawaii and none of these had significant titers.[33] The serologic findings are not as helpful here as in Rh titrations. Demonstration of immune A and B antibodies in the mother's serum means only that there may be ill effects on the baby. However, most feel that the absence of immune A and B virtually rules out hemolytic disease in newborn due to ABO incompatibility.

"Diabetes is common among Hawaiians but they rarely develop ketosis and coma."

From the analysis of The Queen's Hospital Diabetic Clinic data by Berk *et al.*,[35] almost one-fifth of the 232 cases were Hawaiians, about one-third

[25] (a) Stitt, P. D., and Levine, M.: The possible existence of clinical toxoplasmosis in Hawaii, HAWAII M. J. 12:351 (May-June) 1953. (b) Tilden, I. L.: Congenital toxoplasmosis, HAWAII M. J. 12:355 (May-June) 1953.

[26] Johnson, H. M.: Modern concepts in the treatment and diagnosis of fungous infections of the skin, HAWAII M. J. 7:122 (Nov.-Dec.) 1947.

[27] Paynter, H. S.: Deep mycoses in Hawaii, HAWAII M. J. 13:189 (Jan.-Feb.) 1954.

[28] Lam, F. K., and Price, S.: Histoplasmosis in man, HAWAII M. J. 6:313 (May-June) 1947.

[29] Connor, A.; Bennett, C. G.; and Louis, L. S. K.: Birth weight patterns by race in Hawaii, HAWAII M. J. 16:626 (July-Aug.) 1957.

[30] Bennett, C. G., and Louis, L. S. K.: Demographic factors influencing birth weight, HAWAII M. J. 18:239 (Jan.-Feb.) 1959.

[31] Waller, R., and Levine, P.: On the Rh and other blood factors in Japanese, Science 100:453 (Nov.) 1944.

[32] Levine, P., and Wong, H.: The incidence of the Rh factor and erythroblastosis fetalis in Chinese, Am. J. Obst. & Gynec. 45:832 (May) 1943.

[33] Mermod, L. E.: Personal communication.

[34] (a) Tilden, I. L., and Chang, W. K.: Erythroblastosis fetalis in a Chinese infant with an Rh+ mother, HAWAII M. J. 4:189 (Mar.-Apr.) 1945. (b) Nance, F. D.: Erythroblastosis fetalis and icterus praecox: four case reports, HAWAII M. J. 6:26 (Sept.-Oct.) 1946.

[35] Berk, M. E.; Page, L. E.; and Herbst, V. C. O.: An analysis of The Queen's Hospital diabetic clinic I: Physicians' data, HAWAII M. J. 6:22 (Sept.-Oct.) 1946.

were Caucasians, and other races comprised about 10% each. Proportionately speaking, this indicates a very high incidence in Hawaiians. Department of Health data covering a five-year period, 1949 to 1954, showed the rate in Hawaiians to be approximately 56 per 100,000 as compared to 36 per 100,000 in Caucasians.[36]

Our records also support these findings. In a two-year period, 1957 to 1959, there were 989 diabetics admitted to The Queen's Hospital. Of these, 117 or about 12% were pure Hawaiians; including part-Hawaiians, there were 239 or about 25%. The racial predominance is apparent when one realizes that Hawaiians and part-Hawaiians together comprise about one-fifth of the total admissions, yet accounted for one-fourth of the diabetics. In this period, there were 59 admitted in ketosis. Almost one-half of these were in Caucasians (including Portuguese), and about one-third were in Japanese. But there was only one pure Hawaiian in ketosis, and eight (13.5%) part-Hawaiians.

"Rheumatic fever is as common in Hawaii as elsewhere."

Many years ago, it was the general impression of physicians that acute rheumatic fever did not exist in Hawaii;[37] at least this phase had not been seen clinically, and the pathologists at that time did not recall seeing the acute myocardial changes of rheumatic fever. Studies since have repeatedly shown that rheumatic fever does in fact occur here in its acute form.[38] Even today, however, many local physicians feel that the early manifestations are either atypical or unusual. Rheumatic fever is apparently as common in Hawaii as in many of the large cities in the United States,[40] and the acute manifestations clinically do not seem to be different or any less apparent[1d] and the morphologic findings of acute rheumatic fever are seen, though infrequently, by local pathologists.

Berk and Hartwell[1c] found a high incidence in Puerto Ricans, Hawaiians, and a mixed group. One-half of the cases from a rheumatic fever clinic were in Hawaiians, 14% in Japanese, 12% in Filipinos and only 1.4% in Chinese. Clinically, 20.5% had an insidious onset.[1d]

[36] Sloan, N. R.: Diabetes in Hawaii, Part I: prevalence, HAWAII M. J. 18:485 (May-June) 1959.

[37] (a) Hartwell, A. S.; Berk, M. E.; Min, T.; Hasegawa, M.; Ishii, A.; and Kuramoto, K.: Heart disease on the island of Kauai, HAWAII M. J. 16:398 (Mar.-Apr.) 1957. (b) Doolittle, S. E., and Tilden, I. L.: Rheumatic heart disease in Hawaii, HAWAII M. J. 1:7 (Sept.) 1941.

[38] Berk and Hartwell, [1c] Connor and Yoshina, [1d] Hartwell, and others,[37a] Doolittle and Tilden,[37b] Leedham and Smith,[39a] Hartwell and Lam.[39b]

[39] (a) Leedham, C. L., and Smith, K. A.: Rheumatic heart disease in inductees in Hawaii, HAWAII M. J. 11:211 (Mar.-Apr.) 1952. (b) Hartwell, A. S., and Lam, J. W.: Heart disease in Hawaii, HAWAII M. J. 3:71 (Nov.-Dec.) 1943.

[40] Berk and Hartwell,[1c] Leedham and Smith.[39a]

"Lupus erythematosus is common among the Japanese."

Judging by the cases admitted to The Queen's Hospital in the past ten years this is apparently true. Of interest is the fact that from 1950 through 1955, there were as many cases among Chinese as there were in Japanese. In the ensuing five years, the number of cases in Japanese increased to such an extent that of 88 cases, 52% were Japanese, 27% were Chinese, and 3% were Koreans. There was one Hawaiian-Caucasian, but the remaining 17% were of mixed oriental background. Thus, in our series, pure and part Orientals accounted for 99% of the cases.

"The Filipinos have a high incidence of hyperuricemia and gout."

In a study of 100 Filipino males from the Outpatient Clinic of The Queen's Hospital, Fisher[41] found 50% to have hyperuricemia and 32% to have gout. A recent study on the Island of Hawaii by Steuermann and Farias with a larger series of cases further supports these findings.[42]

"Sarcoidosis is rare in Hawaii."

Only a few cases of sarcoidosis have been encountered in Hawaii over the years. It is believed that there are no definitely proven cases in persons born and raised in Hawaii.[43] A study is in progress to investigate this point as well as certain other aspects of this disease.[44] The possible role of the pollen of pine trees in the etiology of this disease is of interest since these trees do exist here in Hawaii, although they are relatively few and young at the present time. The sudden appearance of a group of cases amongst local persons may afford an excellent opportunity to establish the agent or agents of this disease.

"Striking racial differences exist in the incidence of different tumors."

Racial differences in the realm of tumors are most interesting. Many of these impressions are based on a relatively small series of cases. It would be necessary to know the racial breakdown of the patients attending the clinic or the hospital from which the data are derived.

Conger reported that the Caucasian man has ten times the incidence of carcinoma of the prostate

[41] Fisher, H. W.: The diseases of Filipino men, HAWAII M. J. 18:252 (Jan.-Feb.) 1959.

[42] Steuermann, N., and Farias, A. H.: Hyperuricemia in Filipinos, HAWAII M. J. 20:151 (Nov.-Dec.) 1960.

[43] Harbinson, J. A.: Sarcoidosis in Hawaii: Case report and discussion, HAWAII M. J. 18:496 (May-June) 1959.

[44] Brown, D. W.: To be published.

een in Japanese.[45a] Walter Strode found prostatic obstruction only three times as common in Caucasians as in the Oriental.[45b] The former had seven times the incidence of nodular prostatic hyperplasia. The incidence of carcinoma and nodular hyperplasia in Chinese was greater than in Japanese.

Carcinoma of the nasopharynx is common among Orientals, especially Chinese.[46] In a review of 200 ovarian tumors, Mapp[47] found that the Japanese women in this series have the highest incidence of ovarian dermoids and the Chinese women tend to have the highest incidence of malignant ovarian tumors.

The incidence of hepatoma is much higher in Hawaii than in the continental United States. This is due to the oriental population in whom this condition exists to a much higher degree. Catts and Tamura[48] recently collected 45 cases of hepatoma from Queen's, Kuakini, and Hilo Memorial Hospitals. There were 15 Filipinos and 13 Japanese so that together, they comprised almost two-thirds of the cases. There were seven in the Hawaiian and part-Hawaiian group, five Koreans, three Caucasians, and two Chinese. Since the number of cases is small, conclusions regarding racial distribution should perhaps be limited to the apparent greater frequency among non-Caucasians. It is our impression that the incidence among Filipino and Chinese should be higher than these figures indicate. We base this upon the many cases which were eliminated because autopsy had not been done.

Cancer of the skin is uncommon in Japanese and this is in spite of the fact that a large number of them have been exposed to sunlight by virtue of their occupation as farmers, laborers or fishermen.[49]

Many physicians here believe that carcinoma of the breast in Japanese women is uncommon or even rare. Two studies[50] here in Hawaii showed a relatively low incidence in Japanese as compared with Caucasians. Reviewing the cases occurring in the past ten years at The Queen's Hospital, the incidence in Caucasians was found to be over four times the incidence in Japanese.[51] There were 72 cases in the Japanese group which comprised the second largest group in the series. With this number of cases, it does not seem appropriate to refer to this condition as "uncommon" or "rare."

In Tilden's series of cases from The Queen's Hospital (1922-1936), there were five Japanese. Thus, there is a substantial increase in the number of cases but we have reason to believe that this is associated with an over-all increase in cases of breast cancer, not necessarily limited to this race. The age breakdown does not indicate significant difference between Caucasian and Japanese women. We could not substantiate the impression expressed[50a] that breast cancer in younger Japanese women is increasing disproportionately as compared to other races.

At The Queen's Hospital during a ten-year period, 1948 to 1958, we encountered 251 cases of stomach carcinoma, 119 or 47% of which were in Japanese, 20% were in Caucasians. We found a concomitant high incidence in the young individuals, 15 (6%) below the age of 36. With 13 additional cases from St. Francis and Kuakini Hospitals we studied the clinical and pathologic features of this group of cases.[52] The majority were in Japanese (68%). One of the most outstanding features of this group of cases is the predominance of cases in women. Whereas at older ages the male to female ratio was 2:1, it was reversed in the younger group, the incidence in females being over twice that in males. There were no cases in men below the age of 26, but there were five women between the ages of 20 and 25. Thus, neither age nor sex should deter one from considering the diagnosis of malignancy of the stomach, particularly with a persistent gastric lesion either by symptoms, x-ray, or other studies.

Conclusion and Summary

Medical credos are frequently based on personal impressions with a limited number of cases. Some observations have not been further investigated, while others have not been substantiated by subsequent studies. An example of the latter is the now discredited impression that active rheumatic fever is rare in the Hawaiian Islands. One might expect changes in other impressions with the passage of time. Those observations that have withstood the test of time, with ample support clinically and pathologically, are not only of interest but are of direct value to the physician because they may contribute to earlier and more accurate diagnoses.

[45] (a) Conger, K. B.: The racial incidence of prostatism in Hawaii: A preliminary report, HAWAII M. J. 6:324 (May-June) 1947. (b) Strode, W.: Prostatic obstruction in Hawaii: Surgery and ethnic distribution, Amer. Surgeon 26:428 (June) 1960.

[46] Pang, L. Q.: Carcinoma of the nasopharynx, Ann. Otol., Rhin. & Laryng. 68:356 (June) 1959.

[47] Mapp, L. M.: Ovarian tumors in Honolulu, Hawaii. Their racial frequency and age distribution, HAWAII M. J. 14:218 (Jan.-Feb.) 1955.

[48] Catts, A. B., and Tamura, P. Y.: Unpublished data.

[49] (a) Arnold, H. L., Jr.: Incidence of dermatoses in office practice in Hawaii, Arch. Dermat. & Syph. 53:6 (Jan.) 1946. (b) Allison, S. W., and Wong, K. L.: Skin cancer. Some ethnic differences, A.M.A. Arch. Dermat. 76:737 (Dec.) 1957.

[50] (a) Quisenberry, W. B.; Tilden, I. L.; and Rosengard, J. L.: Racial incidence of cancer in Hawaii: A study of 3,257 cases of malignant neoplastic disease, HAWAII M. J. 13:449 (July-Aug.) 1954. (b) Tilden, I.: Carcinoma of the breast in Hawaii, Trans. 48th Annual Meet. Hawaii Terr. Med. Ass., May, 1938.

[51] Tamura, P. Y.: Data to be published.

[52] Tamura, P. Y., and Curtiss, C.: Carcinoma of the stomach in the young adult, Cancer 13:379 (Mar.-Apr.) 1960.

What's bad—what's good—and what's needed, in Hawaii's program of prevention of preventable diseases.

Public Health in Hawaii, 1960

Report of a Health Inventory

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MANY activities and changes occupy the minds of the people of Hawaii in 1960—a year of appraisal, booming population, building, reorganization, transition, and dedication. The business climate, economic conditions, land uses, transportation, civil defense, management of governmental affairs, the role of voluntary organizations, voting for a President for the first time, and methods of education are receiving attention. Fortunately, increasing recognition is being given to the vital stake of people of all interests in the health of their families, their community, and their neighbors at home and abroad. Health is being more recognized also as a significant factor in Hawaii and in the rest of the world in relation to industry, tourist travel, and commerce.

In view of the significance of World Health for World Peace, it is appropriate to regard health as pertaining to physical, mental, and social well being, not merely the absence of illness and infirmity—the definition of The World Health Organization and its 101 member nations. Few Chambers of Commerce, Departments of Health, and Medical Associations recognize as fully as do those in Hawaii the importance of a healthy environment for the attraction of tourists, for the success of pineapple, sugar, and other industries, and for the safeguarding of military establishments. Business, educational, and industrial leaders are becoming more aware of the basic importance of health for a stable economy. Hence, a periodic inventory of public health fits the constructive pattern of systematic planning for future happiness and prosperity at this crossroads in the Pacific.

The method which was adopted for this public health survey or inventory of the 50th State was similar to that of 1929, 1935, and 1950, when previous comprehensive studies of administration and organization were conducted. Information was obtained from numerous reports of special studies conducted under the auspices of the Chamber of Commerce, the Department of Health, the Oahu Health Council, the Commission on Children and Youth, and the Commission on Aging, among others.

The study was undertaken in January, 1960, and covered a period of over six months. It was conducted chiefly by interviews and conferences, by visits to the departments and organizations most concerned, and by reviews of reports, records, and laws. Data recorded on the new Guide to a Community Health Study of the American Public Health Association were compared with similar data from other areas and from previous surveys made here. Attention was given to progress made during the past three decades, and considerable time was spent, as heretofore, in a scrutiny of the application of the programs in local communities on each island.

Excellent cooperation was received from the representatives of governmental departments studied, and from hundreds of individuals and voluntary agencies on the Islands of Hawaii, Kauai, Lanai, Maui, Molokai, and Oahu, including the Director of Health and members of his staff, who took on added duties in the midst of reorganization and other studies to complete extensive schedules and provide extra information for this inventory. Valuable assistance was rendered by the executive secretary and officers and board members of the Oahu Health Council in the arrangement of schedules, the preparation and distribution of questionnaires, the copying of data, and otherwise. The University of Hawaii provided the services of the consultant and the Public Health Committee of the Chamber of Commerce paid for special secretarial and out-of-pocket expenses. Each island had a special advisory committee or group. Special committees of the medical and nursing associations and hospitals were helpful. Time and viewpoints were given generously by those interviewed throughout the State

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uring the four months of intensive fact gather-
ıg. Grateful appreciation is expressed for this
ıvaluable assistance and for the gracious hospital-
y received everywhere.

ntroduction

This inventory disclosed continuing progress in
ıe development of public health organization and
ervices in Hawaii in line with changing condi-
ions and experiences elsewhere. Major steps in
eorganization are in progress following action by
ıe Legislature in 1959 for the new State. Hawaii
ad a Board of Health in 1850, before any Amer-
an state, in the year which is often mentioned as
he time of the beginning of the modern public
ealth movement in America. A reminder is
ardly necessary of 60 years ago when Honolulu
ad both bubonic plague and conflagration. Sev-
nty-one cases with 61 deaths were recorded in
our months. On Christmas Day of 1899, two
ew cases stimulated burning of plague-infected
reas on Sunday, December 31; and wind-swept
lames then took 60 Honolulu acres from the
vaterfront mauka along Nuuanu stream. Kawaia-
ao Church became a refugee camp for 4500
omeless.

Only thirty years ago, diphtheria, Hansen's dis-
ase (leprosy), and tuberculosis thrived here, and
ss than a third deliveries were performed by
hysicians. In 1929, there were 419 deaths per
00,000 population in the Territory from com-
ıunicable diseases, with 227 in 1939 and 63 in
949. In 1959, there were just 26 from these
auses, an annual saving of 393 per 100,000 pop-
ılation as contrasted with 1929 when the city had
nly a little over 100,000 people. Unnecessary
leaths of infants and of mothers in pregnancy
ıave been reduced dramatically, as will be dis-
ussed later.

Hawaii is blessed with many natural resources
vhich enrich the life of her people; but the mod-
rn comforts and scientific benefits so abundantly
rovided are the results of vision, energy, and
areful planning of community leaders. The con-
inued achievement in the promotion of health
nd the reduction of preventable diseases and in-
apacity indicate foresight, judgment, loyalty, and
kill. The state-wide program of public health,
rovided by the official and voluntary agencies
nd individuals including physicians, dentists,
ıurses and others, is one of the best in America.
The generally apparent attitude of constructive
elf-criticism, coupled with the application of
earching appraisal methods, to find gaps and
veaknesses, preparatory to developing measures
or improvement, gives promise of continuing
rogress in the health program of Hawaii in line
with new scientific advances and tested proce-
dures. Much also depends upon the economic and
social development of Hawaii. As the ultimate aim
of any economic development plan is to raise the
level of living of the people, the investment for
health promotion and protection of the population
constitutes an essential element. The economic
outlook for Hawaii is good according to the ex-
perts in that field.



DR. HISCOCK

This report deals primarily with organization, administration, and future opportunities, and contains only such statistical and detailed descriptive material as may be essential for background purposes. A management survey of the State Government was undertaken in October, 1960, by the well-known firm of Boos, Allen and Hamilton, dealing with such important questions as manpower resources and production, organization, and related factors. Few states have had the benefit of as many careful studies of functional needs and activities by commissions, committees, and consultants, in which also many citizens, professional and nonprofessional, have participated.

More and more emphasis is being given to community health planning. Such planning depends upon the answers to such questions as: "What is the government health policy?" "What is our community? Its population? Its geographic limits? Its health facilities and personnel? The rates of illness and death among its residents?" and many related questions. The APHA Guide to a Community Health Study provides the health needs and an assessment of community health resources.

Consideration has been given to community objectives and plans for future action, to the opinions of many official employees and of members and representatives of various kinds of voluntary agencies as to strengths and weaknesses to weigh with others which were suggested while observing and conferring widely, and analyzing the records. For example, in relation to the population and other features of the state and of parts of the state, including the political organization, are the health services adequate and satisfactorily coordinated? Are there sufficient resources to do the jobs? Are these being used effectively? What additional joint planning and cooperative action are necessary to improve the situation during the next five to ten years?

Previous Health Surveys

Of historical interest, perhaps, is the fact that a health survey of Honolulu was made in 1929 under the auspices of the United Welfare Fund. The report contained some one hundred recommendations pertaining strictly to public health, besides several relating to welfare, which were proposed on the basis of group consideration of needs. All of those recommendations, except for a few details not applicable, were carried out and basic provisions were supplemented and new activities developed. The survey of 1935, under the auspices of the Honolulu Chamber of Commerce, with the cooperation of groups on the other islands, carried six basic and comprehensive recommendations. Most of these proposals were carried out also, including meeting the need for proper qualifications for the chief executive of the Hawaii Department of Health, for a trained health officer on Maui, and for increases in public health nurses. In addition, numerous recommendations of the Postwar Planning Committee, published in 1948, were carried out.

In 1950, there were 24 major proposals. Favorable action has been taken on several of them, including:

1. Changes in organization procedure and legislation to place more administrative control and executive responsibilities on the Director of Health.

2. Provisions of an urgently needed new building for the Department of Health in Honolulu, although it is "outgrown" before occupancy inasmuch as the bureaus and staff members have increased so much by recent reorganization.

3. Additions of needed senior medical personnel in child health and in preventive medicine, and of a Bureau of Adult Health.

4. Strengthened Bureau of Health Statistics.

5. Development of a College of Nursing at the University of Hawaii; now functioning actively, as are the valuable hospital nursing training programs.

6. Provision of central housing for several voluntary health agencies, including the Oahu Health Council.

7. Appropriate support of the policies of the Department of Health to meet more fully the unusually complex health, economic, and social problems of Hansen's Disease.

8. Increased official services in mental health and in mental retardation.

9. Some improvement in salary scales; although still too low for practical purposes for the senior professional positions.

10. Development of an active program for mental and physical rehabilitation.

Strong Features of 1960

Among the strong factors, or assets, in Hawaii, without reference to priorities, are the following:

1. **Reasonably adequate public health laws,** with provision for revision from time to time to keep pace with technical knowledge and experience. A special study in progress to determine changes desirable because o reorganization.

2. **The State Department of Health,** soon to be house in a new central building in Honolulu, which compare favorably with that of the better equipped states in basi structure, in fundamental services, and in qualification of the Director, the Deputy, and the division and bureau heads. There are full-time medical health officers fo Hawaii and Maui Counties and provisions for the sam when a vacancy can be filled for Kauai. Health Depart ment housing has improved on some of the Islands, bu leaves much to be desired on others. Advance program planning and continuing processes of assessment, with wide staff participation, are useful characteristics.

3. **Good support by the general public,** including Chambers of Commerce, and by physicians and dentists who maintain high standards of practice.

4. **General, Hansen's disease, and tuberculosis hospitals,** adequate in number and affording a high standard of services (except for frequent lack of skilled social services); besides a good convalescent nursing home in Honolulu. The state operates a **mental hospital** and steps are underway to develop special sections of general and other hospitals for carefully selected mental cases. A valuable **Shriner's Hospital** is well equipped with personnel and physical resources. There is a well organized and administered **Blood Bank.**

5. Generally good **water and milk supplies;** an effective program for the **control of insects and rodents;** technical supervision of methods for the **disposal of sewage** and other wastes with vigorous efforts in the face of extensive building developments to extend water-carriage systems and treatment so essential for safety; necessary educational and enforcement measures for safeguarding food supplies and informed staff members to help in reducing hazards from **air pollution and radiation.**

6. A good national and state **park system,** with the grounds maintained in a clean and sanitary manner.

7. Generalized **public health nursing program,** including excellent rural public health nursing.

8. A growing **College of Nursing** at the University of Hawaii; with cooperation established with appropriate hospital training and service programs, including Tripler Hospital among others.

9. Officially operated **central registers for cancer** and for **tuberculosis cases.**

10. Essential **voluntary health agencies,** including cancer, crippled children and adults, dental pre-school clinic (Strong-Carter), heart, mental health, mental retardation, poliomyelitis, and tuberculosis, among other professional and lay organizations.

11. Community **rehabilitation programs,** including physical medicine, vocational training, and sheltered workshop, in varying degrees of development provided on the different islands, and receiving attention to broaden further their scope and depth of content.

12. Reduction of all **communicable diseases** and high immunization protection. The well organized and operated public health laboratory services will soon have more adequate quarters in Honolulu, but there is desperate need for better space on Maui.

13. Several important **research studies** in progress which relate to health, and increasing interest to develop new studies, with increasing efforts toward coordinated planning.

14. Services in the health department for **alcoholics,** financed through a percentage of the liquor tax, and a State Committee on Alcoholism.

15. Well planned and operated **Civil Defense** program roperly related to health and medical affairs.

16. Trend away from institutional care of persons hose needs can be met in home settings as illustrated y the Department of Social Services recruitment of **personal care" homes** on Hawaii and Kauai, where no home" staff medical and nursing services are needed.

17. Active **Oahu Health Council,** although on limited udget and staff. Several voluntary health agencies are oused near together in the Health Center building wned by the Oahu Tuberculosis and Health Association n Lunalilo Street. There is a strong cooperating **Council f Social Agencies** in Honolulu, a useful health and wel- are council on Kauai; and reactivation of Councils on Hawaii and Maui under consideration.

18. Active **Public Health Committees** of Chambers of ommerce; and a growing State Chamber of Commerce ith concern for the health of the people as well as for ie business climate.

19. Good **communication facilities** by air, highway, hip, and telephone, being expanded in accordance with eed.

20. Relatively favorable **economic status,** low unemployment, high spendable money income, increasing tax ates, high standard of living and of education combating ignorance, hunger, and poverty, and offering substantial resources for the purchasable commodity—public health.

21. A continuing program for **in-service education** of taff and board and committee members of the Department of Health; besides useful quarterly staff meetings enhance opportunities for inter-communication and urrent understanding of developments for all concerned.

22. **Devotion to duty,** with loyalty, being demonrated by members of the staffs, and by boards and ustees of official and voluntary health agencies.

Weaker Features of 1960

Weaker features of the health programs, or liabilities, are the following:

1. **Too low salary ranges** available for public health ersonnel especially for the Director, the Deputy, and eads of important units in the Department of Health, n comparison with those of several other states with hich Hawaii must compete for qualified personnel. his practical situation is coupled with **cumbersome civil ervice and budgetary requirements** and operation, including "position control," in spite of some improvements in the past 10 years. This is expensive in delays nd restrictions in securing and holding badly needed nd qualified medical and other technical personnel, in ie midst of unattained objectives and unfulfilled ambions in essential mental health, mental retardation, and ther administrative public health services.

2. **Personnel shortages,** lack of sufficient understudies nd deputies, as needed for: (a) local health administration and especially for Oahu (the present deputy occupying three major positions with great ability but hile he and the Director carry overwhelming burdens); b) public health engineering (with the mounting probems of sewage disposal on all islands and the upsurge f building); (c) for medical guidance in occupational ealth; (d) health administration for Kauai and Niiau; and (e) keeping pace with the increases in popuation and occupational and housing problems carrying eavy health agency responsibilities.

3. Complexities in the administration, and in the interpretation to the public and to various community agencies, of the program of **medical care of the so-called medically indigent.** There are likewise complexities in efforts to insure understanding of the logic and economy of keeping preventive services and therapeutic services integrated. There is apparently lack of adequate financing for both indigent and medically indigent, besides limitations of program relative to rehabilitative services, to short-term psychiatric care, uniform dental care, and preventive care. (Medical care administration details are beyond the scope of this study. The responsibility now rests with the Department of Social Services, but there is an impact on several different aspects of the public health program. The law seems to divide responsibility for administration between the State Department of Social Services and the county governments. The responsible State Department is making strenuous efforts to clarify and improve conditions related to this newly acquired program, a service which is causing anxiety in many other states.)

4. **Lack of a real hospital council,** or of including such council activities in the Health Council (although again, details of hospital management and practices are beyond the scope of this inventory).

5. Gaps in services for **dental health,** both for adults and children, for **nutrition,** for **health education of the public,** for **social services** and case work in most hospitals and in rural areas. Modern **child health conference** types of services are quite limited. This may be serious for those who do not receive them from private physicians. This unfortunate situation may be partly related to: (a) the antiquated means test policy, (b) inadequate staff, (c) pressure of some physicians who apparently are unfamiliar with purposes and policies of child health conferences, and (d) perhaps other complications.

6. Unusually complex problems of **water supply** and **sewage disposal** on all of the islands, with increased hazards related to building boom and land development, and with **too little support of the use of fluoridation** as a major preventive dental health measure.

7. **Crowding in mental hospitals;** inadequacy of hospital and **"nursing home"** facilities for older persons and others, including younger persons, afflicted with chronic illness and incapacity. The program for the care of **long-term illness** is relatively undeveloped, with shortage of "personal care homes" in counties other than Kauai, with little homemaker service and no bedside nursing service.

8. Incomplete **rehabilitation services for the mentally ill and handicapped;** and only limited inpatient and outpatient treatment services for mentally ill children.

9. Inadequately coordinated and unsystematic planning of **research projects** in health and medical affairs on the part of the various organizations involved.

10. Incomplete organization of **volunteer services,** except for the volunteer service bureau in Honolulu, a new organization on Kauai, and for some hospital auxiliaries, the Clipped Wings Club, and the Junior League.

11. Small number of selected men and women from Hawaii, on **fellowships,** for important positions in public health and other sciences.

12. Lack of **"home care programs"** (with extension of hospital services into the home) by which patients would receive appropriate care economically and efficiently; and unnecessary hospital construction and maintenance would be lessened.

13. Continued use of sub-standard institutional facilities for the **care of aged, convalescing, and chronically ill** persons necessitated by shortage of other provisions,

and incomplete acceptance of their importance, for persons many of whom would be better off in noninstitutional settings.

14. **Nonfluoridation of water supplies** except by military installations.

15. Inadequate means of keeping professional persons, including social workers and teachers, up to date with scientific knowledge concerning **nutrition, mental health,** and general personal and public health.

16. Gaps in measures for **health education of the child** of school age and his parents, and in communication and coordination within the governmental programs. Furthermore, **pupil and student health services** in both public and private schools and in the colleges and in the University of Hawaii may leave much to be desired.

17. Too limited provision of prepared professional **health education** staff members of **voluntary health agencies.**

18. Problems of securing proper membership and representation on boards and committees of the **voluntary health agencies** which are increasing in numbers and need wise and representative leadership to insure constructive programs of service.

19. Insufficient provision for attendance and participation by all categories of public health workers in national and state **health conferences.**

20. **Incomplete coordination of essential health services,** with lack of health councils or committees on Hawaii and Maui and only partial coverage of essential groups on Kauai, Molokai, and Oahu. There is need for greater citizen involvement in community planning, determination of priorities, policy formation, communication and interpretation of needs, resources, and services, coupled with a growing number of fund raising campaigns and of organizations.

21. **Limited financial support of the Health Councils** by the many voluntary and official agencies engaged in health, medical, dental, hospital, nursing, and health insurance programs, for whom such Council services are invaluable and time-consuming and require imagination, initiative, and follow-through efforts.

Findings and Discussion

A brief description will be given of the background and highlights upon which the above-outlined 22 strengths and 21 weaknesses are based. More detailed descriptions of functions, needs, and services have been prepared separately for each island and are filed with the Health Council and the Health Departments and the Hawaii Medical Library.

The State and the People

Hawaii's population of 620,346 on April 1 of 1960, including some 42,000 armed forces personnel stationed in Hawaii, is distributed over an area of 6,407 square miles including eight major islands and many islets and reefs. The population increased 24.1 per cent in ten years—38.5 per cent on Oahu. These islands are famed for their beauty. Some of the islets are so low that they are partly awash at high tide. The two 13,000-foot volcanic peaks, Mauna Kea and Mauna Loa, rise more than 26,000 feet from the floor of the su rounding ocean, making them the tallest volc noes, above their base, in the world. There a eight main islands spread in a slight arc about 37 miles long from northwest to southeast.

Hawaii, known as the "Big Island," covers a area just over 4,000 square miles. The other si which are permanently inhabited—Kauai, Lana Maui, Molokai, Niihau, and Oahu—are eac about as large as a small or average-sized coun in the eastern United States. Kahoolawe is but 4 square miles in area, is uninhabited and is used a a target ground by military planes. But the peopl of the new state are living in five counties, wit 78.8 per cent in Honolulu, 9.8 per cent on Hawai 6.8 per cent on Maui (including 0.8 on Moloka and 0.3 on Lanai), 4.5 per cent in Kauai, and le than 0.1 per cent in Kalawao (on Molokai) While the principal islands are separated by bodie of water of the Pacific, six are quickly and easil reached by airplane services.

The Hawaiian Islands lie in the path of th northeast trade winds, hence the northeastern windward side of the mountainous ones is rainy and the southwestern, leeward side is dry. Averag sea-level temperatures in Honolulu range fro 67.2° F. during the coolest month to 82.9° F. du ing the warmest. The vegetation of the island ranges from lush tropical rain forest to dry gras cactus conditions. Most of the present types o vegetation were introduced from many parts o the world.

The people are mainly American-born (84. per cent in 1950), of United States citizenshi Over half are of oriental ancestry: some 36.9 pe cent Japanese, 6.5 per cent Chinese, 1.4 per cen Korean, and 12.2 per cent Filipino in 1950 (mor recent data are not available). In 1950, onl 12,206 unmixed Hawaiians (Polynesians) re mained. After many years of experimentation wit tropical crops, the islands settled upon sugar can and pineapples as the most lucrative and suitabl to the climate, marketing, and general economi conditions of the environment. The labor forc needed was drawn from many parts of the world but predominantly from the Orient.

The usually mentioned big three of the econom are sugar cane, pineapples, and the tourist indus try. But the largest factor in the economy is th Armed Forces spending; expenditures in 195 amounted to $338 million. The value of the suga produced in that year was $131 million, of pine apples about $127 million, and of the touris trade $109 million (Bank of Hawaii mid-yea report, 1960).

The fishing fleet, manned principally by person of Japanese ancestry, supplies local markets, an

fish for a tuna cannery. Manufacturing consists principally in food processing, the maintenance and repair of shops, the making of clothing, furniture, machines used on the plantations, and articles for sale to tourists, besides the processing of mainland raw materials. The diversified agriculture—flowers, fruits, nuts—is important. The standard of living is similar to that of the rest of the United States. Since 1955, the increase of population has not been matched by a proportionate increase in the number of jobs.

There are some 225,000 employed civilians in the population who, together with military personnel, produced a total personal income (estimated by the First National Bank) of $1.3 billion in 1959. The August 1960 Survey of Current Business showed total wages and salaries as $975 million. Standards of living have been rising.

In 1959, there were 17,093 live births in Hawaii and 3,247 deaths from all causes among residents. In addition, there were 62 deaths among military personnel and 68 nonresident deaths. Here as elsewhere in the modern world, heart diseases lead the list of ten principal causes of deaths, with cancer and other malignant neoplasms second, and accidents high in this group.

Leading Causes of Deaths of Residents, State of Hawaii, 1959

Rank	Cause	Number	Rate*	Per Cent	U.S. 1959 Rate
	All Causes	3,247	543.0	100.0	941.7
1	Diseases of the heart	1,058	176.9	32.6	366.3
2	Cancer and other malignant neoplasms	585	97.8	18.0	147.1
3	Diseases of early infancy	282	47.2	8.7	38.5
4	Cerebral hemorrhage	265	44.3	8.1	.....
5	Accidents, all forms	165	27.6	5.1	50.7
6	Influenza and pneumonia	118	19.7	3.6	32.5
7 & 8	Diabetes mellitus	83	13.9	2.6	16.0
	Congenital malformations	83	13.9	2.6	12.3
9	Nephritis and nephrases	46	7.7	1.4	.....
10 & 11	Cirrhosis of the liver	42	7.0	1.3	11.0
	Suicide	42	7.0	1.3	.....
	All other causes	478	79.9	14.7	.....

* Per 100,000 population.

Death rates from maternal and infant mortality are among the lowest in the United States. The last resident case of smallpox in Hawaii was reported in 1913; there are no cases of rabies; there were no cases of diphtheria in 1955-58, but there were two cases in 1959 and one nonresident death from this preventable disease. The death from typhoid fever in 1959 was the first since 1946. Poliomyelitis cases reported last year in Honolulu numbered three last year against 78 in 1958 and 189 in 1955. But 783 cases of gonorrhea were reported in 1959, with 139 cases of syphilis—an increased trend upward after a decrease. The decline in the number of cases of tuberculosis has not matched the dramatic decrease in the death rate with 436 new cases registered and only 16 deaths —mortality rate of less than three per 100,000 population.

Striking changes in vital statistics in Honolulu City and County, for example, are shown in the following tabulation, while remembering that about one third of babies in Honolulu in 1929 were delivered by midwives, one third by physicians, and one third by someone in the household.

Selected 1958 Statistics for Honolulu and Rural Oahu

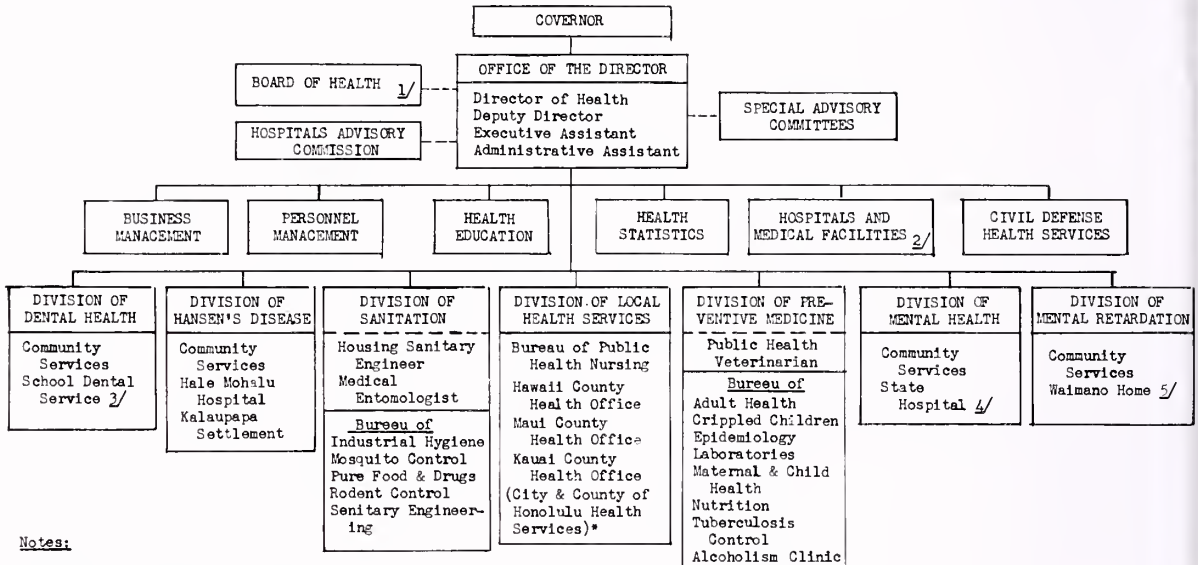
	HONOLULU		RURAL OAHU	
	By Residence	By Occurrence	By Residence	By Occurrence
Livebirths	8,477	12,357	5,357	1,558
Rate per 1000 civilian papulation	27.6	.....	39.3	.....
Premature births 8.5 per 100 (approx. number)	997	1,047	630	124
Infant deaths	219	.....	97	.....
Death rate per 1000 livebirths	25.8	.....	18.1	.....
Out-af-wedlack births	469	.....	212	.....
Out-of-wedlack birth rate per 1000 livebirths	55.3	.....	39.6	.....
Hame deliveries by M.D.	23	.....	40	.....
Hame deliveries by midwives	10	.....	3	.....
Hame deliveries informant	16	.....	38	.....
Father in armed farces	2,390	.....	2,538	.....
Percentage of births in military families	28.2	.....	47.4	.....

Practically all births on all of the islands (99.3 per cent) now occur in hospitals. Few midwives carry on their former services and then only incidentally, for the most part, as a somewhat emergency activity.

Responsibility for Public Health

As with a business organization, so also with public health, there must be a proper design for the division of work and a delegation of responsibility. This statement was made by a former president of the state and territorial health authorities. The functions and responsibilities of the state and federal government have been increasing over the years. Furthermore, both the federal government and voluntary agencies have legitimate responsibilities in this field.

INITIAL ORGANIZATION OF DEPARTMENT OF HEALTH
STATE OF HAWAII



Notes:

1/ Reconstructed as advisory board.
2/ Medical care function transferred to Department of Social Services.
3/ Transferred from Department of Public Instruction.
4/ Transferred from Department of Institutions.
5/ Transferred from Department of Institutions.

* All units on Oahu provide services to City and County of Honolulu.

January 20, 1960

The United States Public Health Service administers foreign and domestic quarantine, and regulates the manufacture and licensing of biological products. It provides medical care to certain persons designated by law, in its 16 hospitals and 125 outpatient clinics and offices throughout the country, conducts research investigations in public health, and cooperates with state and local health officials and with universities. As an illustration of grant-in-aid funds, during the year ending June 30, 1959, payments were made to Hawaii amounting to $787,000 besides the allocation of $1,000,000 toward the care and treatment of patients with Hansen's disease.

Essential health services in behalf of mothers and children, including crippled children, are furnished by the Children's Bureau, through the Department of Health. The Army, the Navy, the Air Force, the Veterans Administration, and a variety of other federal agencies furnish additional health services, as illustrated later. Voluntary or nonofficial agencies provide a significant portion of the financial support of all public health work in the United States and are needed to supply important services which an official agency may not be equipped or ready to render.

In the long run, the maximum economy in state expenditures for the mental and physical well being of the citizens is conditioned upon the provision of an adequate prevention program. For example, prevention of occupational diseases, industrial and home accidents, and of tuberculosis and syphilis, is less expensive than treatment of physical conditions resulting from these causes.

Organization

During the last year of operation of governmental services under the Territory, there were 89 to 120 separate units reporting directly to the Governor. The Constitutional Convention of 1950 brought attention to the need to bring the activities into 20 departments, one of which was Health. In the present organization chart, in fact, there are 18 departments listed.

The Department of Health is the organization chiefly concerned with features of public health shown on the above chart. The major activities of each section and the background of public health in Hawaii are described elsewhere in reports and special bulletins of the Department of Health and of the Public Health Committee of the Chamber of Commerce.

In 1959, before reorganization, there were only 600 positions. There are full-time medical health officers on Hawaii and Maui (also serving Lanai and Molokai), but the position is vacant on Kauai (also responsible for Niihau). The Deputy Health Director of the State carries this responsibility on Oahu and serves also as director of local health administration.

The distribution of personnel among administrative units as of the first of June, 1960, was as follows:

Division of Administration	37*
Division of Dental Health	46†
Division of Hospitals and Medical Facilities	3½
Division of Local Health Services	39
Bureau of Public Health Nursing	104
Division of Mental Health	48
State Hospital	404
Division of Mental Retardation and Waimano Home	316
Division of Preventive Medicine (including Adult Health, Crippled Children, Maternal and Child Health, Nutrition, Epidemiology, Tuberculosis, Laboratories)	202
Division of Hansen's Disease	124
Division of Sanitation	187
Division of Specialized Services	
Health Education	7
Health Statistics	16
TOTAL	1,533½

The state appropriations for the Department of Health for the fiscal period ending June 30, 1961, amounted to $7,636,243 (exclusive of federal and special funds) divided as follows:

	NET STATE APPROPRIATION	SPECIAL	FEDERAL FUND
General Administration	$ 179,396	$	$ 26,226
Dental Health	234,323	.....	800
Hospital and Medical Care	29,677	.....	200,000
Local Health Services	689,039	.....	53,745
Mental Health Hospital	2,485,375	450	45,275
Community Services, Mental	375,667	.....	28,043
Preventive Medicine	629,263	.....	304,440
Sanitation	956,028	6,890	31,398
Specialized Services	116,975	500	17,701
Hansen's Disease	228,258	.....	1,200,000
Waimano Home	1,532,602	50,000	.....
Parole and Home Placement	29,412	.....	.....
Mental Retardation	150,228	.....	.....
Special Research Projects	.....	.....	60,949

New positions were granted chiefly for mental retardation services. This budget is bolstered in vital parts by federal grants, including research. But provisions for travel, even inter-island, and for visits to the mainland were too limited for greatest efficiency of operation.

Fortunately, the housing of the Department of Health, as previously mentioned, will soon be greatly improved by the new four-story building in Honolulu.

* Noteworthy is the fact that the size of staff in the office of the Director has remained unchanged for years.

† Of whom 42 are dental hygienists, including vacancies.

The State Department of Health is well administered and is performing many essential services in an able manner. It needs reinforcement still to provide for a more stable administrative staff structure, as emphasized above. The Department has the confidence of both professional and nonprofessional groups. The health regulations and even the statutes may need further revision to facilitate the operation of parts of the machinery entailed in the reorganization. Also, a management survey is needed as proposed by the Director of Health, to insure maximum effectiveness following a merger and additions to functional services of the magnitude recently experienced. The stepping up of salary scales, as proposed above, is a matter of urgency.

University of Hawaii

The University of Hawaii is located in Honolulu, on the island of Oahu, three miles from the business center and two miles from Waikiki, in Manoa Valley—one of the picturesque sections of the city. The Manoa Campus and ten other tracts on the islands of Hawaii (with the Hilo Campus), Maui, and Oahu, bring the landholdings to 710 acres. Enrollment in 1959 totaled over 8,800, with some 6,900 studying on the Manoa Campus, 250 in Hilo, and over 1,600 in evening courses, besides 700 in noncredit courses. The faculty of over 500 is supplemented by more than 100 research assistants. The University includes a Graduate School, a School of Social Work, in addition to seven colleges, one of which is Nursing and another, Engineering, among those especially related to public health affairs. Speech, hearing, and reading clinics offer technical training, make diagnoses, and give therapy for disabilities to both University and non-University people. There is a good Library with exceptionally strong collections in atomic energy, world health, and the Far East and the Pacific Ocean area; a useful Legislative Reference Bureau; and a growing Audio-Visual Aids Center. There are strong Departments of Microbiology and of Psychology, among others of a supporting nature for a Department of Public Health. A Health Research Institute is in the planning stage, with considerable money allocated by the State and the Federal Governments for the building and equipment.

A bill passed by Congress and signed by the President of the United States authorizes the establishment in Hawaii (under State Department auspices) of an International Center for cultural and technical interchange between the two hemispheres. Attention to public health and health education is indicated in the initial plans for this important center.

Opportunities for conferences, of which the international conference in philosophy is an excellent example, special studies and workshops have been provided and used advantageously.

Up to the present time, funds have been lacking for a comprehensive university health service; although consideration is being given to more adequate resources. A need exists for more emphasis on health and on nutrition in the preparation of students for work later in various professional duties. A greater contribution can be made on this campus through expansion, as the need is indicated, of the summer and special conference and study programs with particular reference to mutual interests of men and women of the Pacific area in affairs of health and of education.

The research facilities of the Bernice P. Bishop Museum and of the hospitals and medical groups, with their able scientific personnel, are a great asset in Hawaii, along with those of high calibre on a modest scale in the State Department of Health. The need and opportunities are being explored for a Department of Public Health closely associated with the newly planned Health Research Institute and the International Cultural Center and cooperating with the fine existing medical and nursing and public health organizations in the 50th State. Likewise, the need is recognized for a full-time experienced medical director of the University health service, with an adequate staff, including more provision for psychiatric counselling for the benefit of all concerned.

Department of Public Instruction

Several activities in the Department of Public Instruction, in Honolulu and on all of the Islands, serve as a part of the public health program, while others are related. It is important that teachers are provided in institutions for pupils who are afflicted, in most instances temporarily, with Hansen's disease, tuberculosis, and for handicapped children in schools for the deaf and blind, in the Shriner's Hospital, and elsewhere, besides teachers especially trained to assist pupils with cardiac, hearing, speech, and vision problems.

A new Teacher's Guide on Health and Safety Education for the public schools of Hawaii should prove helpful in the program of health for the school age pupils and the teachers. The program objective, responsibility, and some aspects of administration and instruction have been described effectively. The major objective of the school health program is good health, physical and mental, and the development of attitudes, habits, and understandings about personal and community health which will lead to a healthy and happy adjustment to life for each child. The conditions under which children live in school, the help they are given in solving their health problems, the ideals of individual and community health which they form, and the information and understanding that they acquire of themselves as human beings, influence the development of attitudes and behavior conducive to healthy, happy, and successful living. In all of its efforts the school must consider the total personality of each pupil and the mutual interdependence of physical, social, and emotional health.

It is recognized that parents have the primary responsibility for the health of their children. This obligation extends to all aspects of health, and schools may not assume the responsibilities of the parent. Under no circumstances may school personnel administer medication to pupils. For a complete understanding of the respective roles of the parents and the school, it is agreed that adequate lines of communication for interpretation, counselling, and assistance between the school and the home must be maintained.

School health as visualized here, and contained in the Guide, is a four-fold program:

1. *School Health Instruction.* Health instruction is the process of providing learning experiences to children for the purpose of influencing knowledge, attitudes, and conduct relating to individual group health.
2. *School Health Services.* Health services are those school health procedures and practices which are established for the purpose of (a) finding children with health needs; (b) following up of children in need of care, interpreting health conditions, and providing health guidance, through contacts with children, parents and community agencies; (c) communicable disease prevention and control; and (d) providing emergency care for the sick or injured.
3. *Healthful School Living.* Maintaining an environment conducive to growth, learning, health, and safety is a part of the school health program. The emotional tone of the school which reveals an understanding of the needs of children is as important as the physical environment.
4. *Health Aspects of Physical Education.* Play and physical education contribute much to the health of children and youth.

While the school health program is a cooperative effort of the State Department of Public Instruction, the State Department of Health, and many cooperating agencies, it is administered by the State Department of Public Instruction. The State Board of Health recommends state health regulations. The Department of Health promulgates and enforces these regulations and provides consultative services and some health services in the school, including public health nursing and environmental sanitation. In each school, the direction and implementation of the school health program is the responsibility of the principal. It

s emphasized, therefore, that he understand and promote the health program in the general education program. Since teamwork is the core of any good school health program efforts are made to have the areas of responsibility of school health personnel mutually understood. The principal, as the team leader, makes provision for the functioning of necessary health services, gives direction through program planning and supervision to health instruction, and is responsible for maintaining a healthful and safe environment, as a policy. There may be variations in execution depending on numerous factors. The District Superintendent has the responsibility for the coordination of the school health program within his district. He works within the policies, plans, and procedures approved by the State Department of Public Instruction, and receives technical and supervisory assistance for the school health program from the state offices. The state offices are responsible for the development and review of state policies and plans for the school health program. These policies and plans are developed cooperatively with the district offices and schools and are approved by the State Department of Public Instruction. The state offices are responsible for giving technical and supervisory assistance in the implementation of the school health program by the district offices and schools.

Health instruction is regarded as the key to developing desirable attitudes, habits, and understandings in the area of healthful living. School health services function effectively where the teachers and children help in integrating health instruction and health services and children have the opportunity to participate and cooperate intelligently. A balanced program can best be achieved when planning for health instruction is part of the over-all curriculum planning and when it contributes to education as a whole. State, district, and school staffs need to understand the place of health instruction and health services in the school program so that a consistent, continuous, sequential school health program can be developed for the state. The principal and his staff consider the special needs of the individual school. Each school staff member has the responsibility of adapting the instructional program to the needs of each pupil under this supervision. Curriculum guides in health are necessary to aid teachers in planning for and carrying out their duties.

Some attention has been given to nutrition, and staff is employed in the school lunch program of Home Economics Education. Some features of the Vocational Rehabilitation Service, especially educational, relate to the community health program also, with a special staff. Of more direct connection in relation to a strictly health program were the provisions for many years for Dental Health Education, recently transferred to the Department of Health. The other main section in the health program has been the Division of Health Education with a staff of home instruction teachers, speech therapists, health coordinators, audiometrists, clerks, and only a very few classed as health educators. Another strong factor in the program for school health deserves emphasis for long-term planning. Increased help is coming from the Joint School Health Committee of the Departments of Health and of Public Instruction. Perhaps one of the most important tasks is to give implementation to the use and full understanding of the new Guide from which extracts have been given above.

The Department of Social Services

This Department, formerly the Department of Public Welfare, has direct relation with health, dental, and medical affairs at several points and the Director of the Department of Health and the Director of Social Services are ex-officio members of the Boards concerned. The administration of medical affairs for the indigent, including operation of government physicians, was transferred by reorganization to this Department. The Department of Social Services was created "to administer programs designed to improve the social well-being and productivity of the people of the state." An experimental or pilot screening team functions with a physician who is employed by this department and a psychiatrist, plus staff members from several other departments serving as resource personnel, and their work in its initial phase promises to determine more closely the conditions of health and welfare of individuals on the rolls and in taking steps toward rehabilitation and employment. The operation now, as in 1950, in relation to costs of medical care for indigents, is unusually complex, with payments to general hospitals on a cost basis, and with somewhat similar practices for county hospitals, and without any remuneration of physicians rendering care, except in rural areas and a few special situations. The Department lacks a full-time medical director or chief of the medical treatment service, and salary allowances are low, although the stipends and drug allowances for government physicians are being increased and adjusted to be more equitable.

The official agency primarily responsible for work in conservation of vision and prevention of blindness is the Bureau of Sight Conservation and Work with the Blind, which is administered in the Department of Social Services. This important work has a relation on the medical side to that of

the Bureau of Maternal and Child Health of the Department of Health, while it is also related actively from the educational and rehabilitation standpoint to many activities of the Department of Public Instruction; certain features relate to the services of both departments. Plans are in progress for a new building close to that of the community Rehabilitation Center and near the Children's Hospital and the voluntary Child and Family Service.

Other services in this major Department include, for example, prisons, training schools, public housing, veterans' affairs, paroles and pardons, and family, child and adult welfare, including economic assistance and rehabilitation.

Military Services

Hawaii is the first outpost of America's health defense, as stated in earlier reports. The health of Hawaii is of extreme importance to the rest of the United States and to the Army, the Air, and the Navy and Marine Forces. The contribution of these military service groups is considerable through cooperation in the operation of hospital and consultative services, and in many other ways, including support of civilian health services. A major installation under the supervision of the Army, but administering care to the members of all services is the 12-story 1000-bed Tripler Army Hospital. This 375-acre installation includes the main group of hospital buildings, a separate neuropsychiatric building, and men's, nurses', and medical officers' family quarters and recreational facilities. A total of 110 beds are allocated to veterans and other beds are made available to the U. S. Public Health Service. Facilities and space are available for expansion to accommodate over 1,500 patients. Cooperation is given in advanced medical training for personnel from the Western Pacific and Far East.

There are many illustrations of mutual interest and cooperative relations in public health affairs between the civilian and military personnel. Noteworthy is the excellent social service program which is of special significance for community health and for the University School of Social Work in view of the serious lack of this in the other hospitals of Hawaii. The pulmonary and communicable disease services and committee activities are constructively inter-related, as are those in radiology, and in nursing. Furthermore, investigation is made by hospital personnel of service people and their dependents who are admitted to Tripler Hospital with a diagnosis of tuberculosis or suspected tuberculosis and a summary is given to the State director of tuberculosis and the nursing consultant. Following confinement, upon request of the medical officer at Tripler Hospital, a member of the State public health nursing staff investigates the sanitary and living conditions of the patient's home before the baby is discharged, besides the follow-up for teaching purposes.

Other Official Agencies

Leahi Hospital is well known as an institution for the care and treatment of tuberculosis patients. It is well organized and ably administered and utilizes the best of modern methods of surgery and other forms of treatment while cooperating with other institutions and agencies on Oahu and other islands. With vacant beds and expert talents, consideration is being given to caring for other types of cases also, perhaps other kinds of respiratory disease and other selected cases of long-term illness which offer promising possibilities of restoration to family life.

On Hawaii, Kauai, and Maui, the tuberculosis hospitals, with new or relatively new buildings, are considering the accommodation of additional types of cases, as for example, carefully selected patients from the crowded mental hospitals.

Attention is being given by officials of various departments and hospitals to the pressing problems of older people, especially the urgent need for more and better nursing, personal care and residential homes.

County hospitals in Honolulu and on the other islands in the State vary in the adequacy of resources, in methods of accounting, and in status of buildings. There are usually many vacant beds in the rural hospitals. These and other factors emphasize the need of continuing assistance in program guidance and planning for the benefit of the patient and the taxpayer.

As time goes on, there seems to be a growing need for community bedside nursing services, perhaps on an hourly basis, and involving uses of trained practical nurses and of visiting housekeeper services (beyond the limited provision of one of the social service agencies) under the supervision of experienced graduate nurses. Associated with these programs, there is a frequently reported need for additional trained social workers in hospitals and in field service agencies. The development of a comprehensive home care program is overdue. Such developments as those embraced in the above-outlined opportunities need to be planned, however, as parts of a properly conceived, technically guided, and wisely executed community health program.

The Voluntary Agencies

The voluntary health movement is a little over 60 years old in the United States and is more extensive there than elsewhere in the world. In Ha-

vaii, these agencies form a permanent and important part of the health machinery and reflect the generosity, genius, and good will of thousands of men and women who give time and money. One of the more fruitful fields for cooperative endeavor is in the provision of liberal scholarship assistance for residents of Hawaii who wish to study in graduate schools in Hawaii and on the mainland to help meet the great shortage of prepared personnel.

With the increasing numbers of voluntary agencies and pressures for board and committee guidance as well as funds, many questions are being raised by different individuals and groups. During the course of this inventory, five questions have been raised frequently to obtain impressions and suggestions for the future, as follows:

1. Are the current health needs of American society of such a nature that they require or respond to the intervention of organized private citizens? If so, what are some examples?
2. If there are such needs, should the organization of private citizens be in the concept of the traditional voluntary health agency, or are there alternative organizational patterns? If alternatives, what are they?
3. Over the years voluntary health agencies have come to mean many different things and to pursue many different programs. Some emphasize support of research, some stress broad social action, some give emphasis to professional education and training, and some place importance upon patient care. Are all of these functions required today? If so, in what order of priority?
4. If the voluntary health agency concept appears valid, and if you could form a "brand new" ideal voluntary health agency, what scope and program should this agency pursue?
5. Assuming that there are differences of many kinds in community problems and organization, how can more joint planning and cooperative action for better community health programs be obtained? What are the first steps?

In Hawaii, a reminder is appropriate that Palama Settlement was one of the earliest of the voluntary agencies in the areas of health, recreation, and welfare. Essential nursing services became a part of official nursing; the dental services were established on a separate basis under the well equipped Strong-Carter Dental Clinic; and since the outpatient department was transferred to hospitals, the health program has been reduced accordingly. Moving pictures from the Department of Health are used at Palama to acquaint parents with matters of health.

An important voluntary agency for educational, library, meeting, and office purposes is the Mabel Smyth Memorial Building, a center of great activity, providing comfortable meeting rooms, especially an unusually comfortable and well equipped auditorium. The medical library, provided by the medical profession to serve the entire state, is bursting at the seams. A new building is planned ($175,000 has been appropriated by the Legislature which will be augmented with private funds). Properly equipped services of library staff will require larger budgets than previously visualized.

There are some 90 official and voluntary agencies concerned directly with public health affairs in Hawaii besides many more that have a less direct or less extensive relationship, such, for example, as ambulance services of City and County and hospitals and first aid services of fire stations, and life saving services at parks.

Special types of voluntary organizations which participate in community health activities are illustrated by the Public Health Committee of the Chamber of Commerce, medical and dental and numerous other professional societies, the American Red Cross, group work agencies, 4-H Clubs, Service Clubs, Congress of Parents and Teachers, Junior League, Federation of Women's Clubs, and Council of Churches.

The voluntary health agency movement illustrates how people will rally to help enjoy the benefits of the conquest of disease and the delights of living. A partial list of voluntary health agencies, exclusive of hospitals, clinics, medical, dental, and nursing societies, includes the following:

Blood Bank of Hawaii
County Chapters of the National Foundation (for Infantile Paralysis originally)*
Hawaii Cancer Society
Hawaii Heart Association*
Hawaii Committee on Alcoholism*
Hawaii Public Health Association
Hawaii Association to Help Retarded Children*
Honolulu Council of Social Agencies
Kauai Health and Welfare Council
Mental Health Association of Hawaii
National Society for Crippled Children and Adults, Hawaii Chapter*
Oahu Health Council
Rehabilitation Center of Hawaii
Tuberculosis and Health Association of the State of Hawaii
Tuberculosis and Health Associations of Hawaii, of Kauai, of Maui, and of Oahu*

The only major health agency in the Community Chest is the Mental Health Association, with a modest budget. During the course of this inventory, joint discussions have been held with representatives of the major voluntary and official agencies in Honolulu, Hawaii, Kauai, Maui, and Molokai and the five questions posed above represent some major items for consideration in the near future, relating to health affairs, except for the joint enterprises which may be developed with the Health Council.

* These six agencies raised some $550,000 in their last campaigns for funds on Oahu.

A Future Step

In looking ahead, one of the problems relates to the importance of improving measures of communication between people and of providing interpretation of plans and programs in an understanding manner. A public educated to know and to act wisely for the protection of its health and the health of others is of increasing necessity if gains in public health are to be made. Parallel with this are well educated professionals who can render service to help meet the demands of the public. Many of Hawaii's major health problems are of noncommunicable type: heart disease, cancer, diabetes, mental illness, dental decay, accidents. Preventing or controlling these conditions rests largely upon individual action, and voluntary organized community action. Such action is the result of health education in many forms by many people, working in partnership. The era of "doing things for people" or of using legal measures to achieve action is waning. Everyone in a health organization should be doing health education constantly, the nurses and the sanitarians having the most frequent opportunities because of their numbers and the nature of their work.

In addition, health education of the public, in a community organization plan, is a basic function of state and local health departments, and an integral part of almost any public health program. Trained† community health educators may be employed in official and voluntary health agencies besides those who are specially prepared in a related manner to carry on "school health education."

In the State Health Department there are four trained health educators of this special category, including the director—three in the central office and one in the Bureau of Adult Health. There are no trained health educators in the local health departments. There are none in the voluntary agencies except three who serve as executives.

The development of health education in the Department of Health in the next decade could well be in three main areas: (1) to strengthen the central office with certain services for all units; (2) to add to the program units and the local health departments trained health educators as part of the staff; (3) to extend and improve training of health department personnel.

Functions of the central office would continue to be provision and maintenance of the following:

Information and interpretation of work and program of department.
Public relations.
Service to other divisions in training and educational method.
Health Education staff development and supervision.
Standard setting in the health education profession.
Inquiry service.
Representing Department at community functions.
Service of graphic arts and printing.
Services to develop, acquire and circulate audio-visual aids and materials.

To carry out these functions there would need to be a basic staff of trained health educators. Additional specialists needed are an Assistant Director, a coordinator of audio-visual services, public relations and information specialists, and additional clerical personnel.

The central office staff would, in addition to basic function, be available on a state-wide basis as consultants to other official and voluntary agencies. The fact that a health educator is a staff member within the Bureau of Adult Health has set the pattern of education being within a program. In such instances the health education is under the administrative direction of the director of the program and receives technical supervision from the central office of health education.

The Department lacks a coordinated training program, and as the educational process is essential to training, the Office of Health Education needs staff to carry out an effective training program in a department of this size. The dual problem of getting positions established by the legislature and getting trained personnel to fill them is the major concern now. Position control by the State Legislature has some unique features in Hawaii, apparently. Also, most states have program budgeting. These may be among many questions of manpower, organization, and production studied by the management experts. As positions become established, local residents with basic qualifications should be recruited to apply for scholarships which would make it possible for the applicant to receive a Master's degree from one of the schools of public health.

In voluntary agencies whose primary function is to support the official agencies, there is a need for qualified health educators. As voluntary agencies have greater freedom than official agencies to conduct programs and to employ necessary staff, they might assist in community health education as long as the shortage of personnel exists.

There are ultimate and continuing needs to be met, as follows:

1. Increased and continuous coordination and joint planning between public agencies and between private agencies, and all together.
2. Increased and continuous cooperation of the health agencies of the various counties.
3. Continuous planning to meet all health needs, giving due consideration of proper relationship with social agencies, hospital, nursing, and medical care institutions, and other bodies concerned.
4. More cooperative planning and joint action for the

† The term "trained community health educators" refers to a person with an undergraduate major in education or the social sciences, and a master's degree in public health.

greatest good of the people of the state as a whole, and for each island, economically and personally and scientifically regarding development; construction and utilization of hospitals, nursing homes (including convalescent hospitals), and "home care" type of services. This relates to wise location, functional utilization, and other aspects of operation approached objectively.

5. Helping with the development by official and voluntary agencies of a program of continuous health education of the public.
6. Special research and reports on specific health problems as needed with action to put recommendations into effect.
7. Central source of health information.
8. Furtherance of needed legislation.
9. Publication of periodic bulletins of value to all agencies.

Health Councils

The numerous voluntary and official agencies serving the people of Hawaii are generally well organized and have sound objectives, comparing favorably with any provided in other parts of the United States. Many have developed good structures and on-going programs. From the standpoint of the community as a whole, however, it is not surprising to find that some of the programs are not related to other agency activities in the same or related "field," and there is inadequate provision for mature staff planning and preparation of material for boards and committees which might lead to use of resources otherwise to better advantage. The mechanism is established in the Oahu Health Council.

This Council was created nearly 20 years ago by the Public Health Committee of the Chamber of Commerce. The accomplishments of the Chamber of Commerce and of the Health Council have contributed greatly to the favorable health picture enjoyed today. Likewise, in related activities, the Cooperating Council of Social Agencies in Honolulu, and the Health and Welfare Committee on Kauai, have helped toward similar objectives. There is opportunity for similar committees or councils on each of the other islands where they have been only partially tried. The time may be near for a state-wide Health Council as previously mentioned in this report.

The Oahu Health Council is continuing to serve an important role in the community as a democratic organization. Each member has a feeling of belonging, of interest, partnership and responsibility so essential for continuing success. This is not "just another organization" to replace existing health agencies. Its objectives and constitution are carefully conceived and allow for essential flexibility in the development and carrying out of tasks based on group judgment. It is properly recognized as primarily an organization for help in program planning, coordination, study—joint study and cooperative action—with aims also to help in interpretation of agencies and activities to the public and to each other, while avoiding specific activity projects of competition with other organizations and agency members. Occasionally, it assists in the work relating to health of member agencies of the Council of Social Agencies. Through the executives of these two Councils, there is careful liaison, augmented by cooperative relations, as indicated, of board members.

More specifically, the Health Council is helpful to the community as a whole in assessing and meeting its total health needs. With a slightly enlarged staff, it could assist more likewise in some aspects of hospital and health center planning. The Council is defined as a community-wide organization devoted to the task of planning and promoting the maintenance and development of a balanced community health program. The theory behind the Council concept is that it can promote more effectively certain programs of common interest than can be done individually. This is possible because the Council brings together the experience, "know how," good will, and other talents of all agencies and individuals interested in a better community. Among many other goals, the Council is a meeting ground where ideas and experiences are shared, unmet needs sought and those needs met cooperatively. It helps to discover serious gaps and to prevent unnecessary duplication and overlapping of services and functions.

The President of the National Health Council pointed out recently a few ideas which have been obtained from experience. Some of these are on the negative side, fully as important to watch sometimes as the positive for long-term progress. For example:

1. A Council can function more effectively if it remains neutral with regard to the question of the method by which the member agencies acquire their funds for their support, other than meeting certain ethical and accounting standards. The Council should provide the means for frank and objective discussion of this important and timely subject, however, when the need is indicated.

2. A Council must make clear that membership does not mean endorsement of the program of a member agency.

3. A Council may develop a plan for an annual forum on a timely subject of widespread significance. The National Health Council has been highly successful with such activities, on subjects including, for example, Aging, Health of People Who Work, Mental Health, Manpower and Health Careers, Long-Term Illness Care, Urban Sprawl. The National Health Council recognized that it should not avoid having as the subject for one of its National Health Forums, one which may be considered controversial, *if* that particular subject seems to be of the greatest current importance to the health interests of the country as a whole; but "we also have established the policy that the Council itself will not come forth at the conclusion of such a forum with a

definite policy statement taking a stand for or against some particular approach or program discussed which might or might not be in accordance with the individual policies of the member agencies."

These concepts do not mean that a Council "is a spineless creature, incapable of exerting any significant influence on the future improvement of the health status of the citizens." The Council can study and clarify confused issues and act as a clearing house for information and opinion. Its authority can be great through exercise of thoroughness, wisdom, and impartiality of its studies and its conferences or forums, and through bringing to the attention of all groups concerned, the changing needs of the health program from year to year. Furthermore, through its committees and other means, it can help to promote more effectively certain programs of common interest than can the individual agencies themselves. Few are the health agencies in 1960 that think they can accomplish all of their own objectives solely through their own endeavors in this year of appraisal and dedication.

"Waves of the sea are overcome by the bow of the canoe;
"Waves of men are overcome by human courage."

The objectives are worth the effort, courage, faith, and patience, well mixed with wisdom, and judgment will be needed; but they are in abundance with the able leadership and skill in Hawaii.

Major Proposals for Long Term Development

The following proposals are offered for consideration in a long term plan of action (e.g., five to ten years) involving only a relatively small new financial outlay, comparatively, with concentration on problems which present knowledge renders vulnerable to attack:

1. That, in line with tested experience nationally, for economy and efficiency and the protection and benefit of the people, the present organization and structure of the State Department of Health be retained as a major independent arm of government, with an able and qualified Director (as at present) reporting directly to the Governor for these most technical of services provided for the taxpayers and all concerned in Hawaii. **The importance of nationally recognized professional qualifications cannot be over-emphasized.** The recent reorganization of services which resulted in the placement of mental health and of mental retardation in the Department of Health was a step in the right direction. The structure of government must include an efficient central health administration to be the responsible government agent for health work and to determine government health policy.

2. That the **tenure of office for the Director of Health** be placed on a **five or six year basis** and not coterminous with the date of the election of the Governor.

3. That continuing appraisal be made, for the benefit of the people served, as to whether **medical care affairs** and the services of government physicians should remain in the newly organized **Department of Social Services,** or be returned to the administrative structure of the **Department of Health,** keeping in mind the peculiar requirements of the State of Hawaii and the individual islands, and also recognizing the complexities of existing legislation. There is no single formula to be applied.

4. That early steps be taken to **adjust inequities in salaries of health department personnel** in line with recognized duties and responsibilities and with other salaries paid and professional incomes in those states on the mainland having the more effective departments with which Hawaii must compete while such properly prepared personnel are in short supply. These include the salaries of the Chief Executive with size of staff more than doubled within the year of reorganization, the Deputy, certain medical and non-medical bureau chiefs, and certain other staff members.

5. That measures be taken to implement the internal reorganization of the parts of the State Department of Health affected by the state reorganization of 1960, including drafting of legislation to meet needs occasioned by reorganization, such as integration of institutional and community services in **mental health** and **mental retardation,** with provision of **more nearly adequate salaries.** It is commendable that an appraisal by a specialist of future mental health program requirements has been made in October of 1960; and that a management survey is in progress by a carefully selected firm of consultants for all state departments.

6. That in the study of problems of management, such questions be included as the **relation of county and state** governmental health activities; the practical aspects of the **"floater" concept;*** and provision for relieving crowding conditions which cannot be remedied in the new building space, and for improvement of housing conditions of the health department for the neighbor island counties.

7. That exploration be continued of the best

* The floater concept, enunciated by the 1960 Legislature, provides that certain specified new positions, called floater positions, shall be created by the Governor only after existing permanent positions have been declared surplus and abolished. The desired effect of the floater concept is to permit program expansions without adding to the number of positions in the State service. The 1960 Legislature placed 119 new positions, 39 of these for the Health Department, in the floater position category. But in the health program, with its shortages, there is the hazard of "robbing Peter to pay Paul."

possibilities for use of **empty beds in sanatoria** designed and used primarily for cases of tuberculosis, such as continuing a "halfway house" plan of caring for selected psychiatric patients and others who may give promise of rehabilitation.

8. That encouragement and cooperation be given by appropriate bodies such as the Department of Health, the Oahu Health Council, and the Chamber of Commerce, to the University of Hawaii toward the development of a **Department of Public Health** for the purpose of graduate teaching, research and consulting services, allied closely with the University Health Program for students, and with the proposed Health Research Institute and the East-West Cultural Center, and cooperating fully with the State Department of Health.

9. That continuing efforts be made to fill vacancies and important new positions in official and voluntary health agencies throughout the State, with help when needed from committees on personnel and training by the Oahu Health Council and by health and welfare committees on each of the other islands, such committees being charged with such duties as the following:

a. Secure more funds from agencies and foundations for pooled **scholarship budgets** to provide for more trained personnel and personnel reserves throughout Hawaii.

b. Continue collection and dissemination of information to high school and university students concerning opportunities for **careers in public health.** There is opportunity to increase more vigorously such work already done along this line by the Oahu Health Council, the Junior Chamber of Commerce, and the Science Clubs Hawaii, among others.

c. Recruit residents of Hawaii for **graduate training** and preparation for public health, and for **travel fellowships** for gaining education and experience in Hawaii and on the mainland.

d. Arrange for **exchange of personnel** with other health groups as provided by legislation now existing.

10. That the **program of the Oahu Health Council be supported more adequately** on a long-term basis. It is recognized that member agencies will be unable to meet the total financial needs of the Council, but there is room for marked increases that would pay good dividends for most of the present members and for many other organizations, including hospital, insurance, and those which are related. Continued support of this valuable program by the Chamber of Commerce and by foundations is in the best interests of the community. Similar councils and committees on public health for each of the other islands would be useful, as illustrated on Kauai and in many localities in other states. Ultimately, a state-wide council of health and social agencies to serve each of the counties and the State as a whole for forum and community planning purposes may be indicated. The experiences of the State Chamber of Commerce may be useful in this connection.

11. That renewed consideration be given to the expressed needs locally on Hawaii, Maui, Molokai, and Kauai, for well prepared **local community health educators,** or consultants in health education of the public, in order to ensure, among other things, better coordination and public understanding of services, and fuller utilization of the voluntary and official agencies in the development of a community health program, including civil defense, and to eliminate duplication of services. Such positions are needed in the state health department budget, but the voluntary health agencies could profitably share liberally in the undertaking and even give priority to allocations in their budgets for launching the service at the outset, under a joint management plan. Additional qualified personnel for health education are seriously needed for Oahu.

12. That renewed consideration be given to recommendation 12 in the 1950 survey report for the development of a **Health Museum of Hawaii.** The beginning effort to have a museum in Honolulu deserves support.

13. That **dental health, social service** casework, and **nutrition** services be expanded, as they are such important elements in the modern public health program.

14. That recommendations of the Commission on Children and Youth, pertaining to better provisions toward prevention, for the benefit of **emotionally disturbed children** and their families, be supported by proper authorities; and that additional solutions be sought to help relieve the complex problems of physical, emotional and social life in the low-income housing areas.

15. That **recommendations of the Commission on Aging,** pertaining to public health be studied carefully with a view to active support by proper authorities of practical features needing attention for the benefit of the "older" persons of the State and of all concerned.

16. That the State Department of Health take the lead in stimulating the development of **"home care programs."**

17. That the essential policy of the State Department of Health of encouraging and promoting **research projects and activities in public health** after careful scrutiny be continued. In addition, active steps should be taken to develop a practical plan for close liaison and cooperative planning between appropriate groups in the University of Hawaii, the State departments, the hospitals, the Bishop Museum, and other scientific bodies with a stake in research in various aspects of public health.

18. That the Department of Social Services continue its recruitment of "personal care" and "residential" homes to provide **noninstitutional care,** whenever appropriate and possible.

19. That the administration practices and policies of the **child health conference** throughout the state be reviewed in the light of the long experience of the U. S. Children's Bureau, the Academy of Pediatrics, and various committees of the American Public Health Association, followed by such steps as may be indicated objectively and practically to insure proper coverage of such services in content and scope.

20. That the use of the new curriculum Health Guide of the Department of Public Instruction be implemented by the appointment of a well qualified **field health coordinator** to help in interpretation and synthesis and future practices toward better health instruction and services for both students and staff members.

21. That renewed consideration be given to the formation of a **Hospital Council,** or to providing a more comprehensive hospital program in the Health Council with an organization composed of members widely representative of the community who may be interested and equipped to assist in constructive future planning. Experiences of Queen's Hospital and others and of the Chamber of Commerce in earlier efforts in this direction might be reviewed through records in annual reports and other ways.

22. That the **staff training programs be "stepped up"** in breadth and depth, both in Hawaii and for mainland benefits, giving, for example, administrative officers responsible for program direction more opportunity to attend professional and technical meetings, while also continuing the well planned meetings, institutes and workshops on timely subjects.

23. That early and vigorous efforts be made to secure increased resources in personnel and supplies to deal with the mounting problems which are barriers to environmental health in Hawaii now and will be more so in the future, including increasing problems of **air pollution,** of **food handling,** of **water supply** and **sewage disposal,** and with the use of **radioactive materials** in commerce and industries.

24. That full use be made of the enlightening information obtained from the Honolulu Household Health Survey, in further follow-up studies and in implemented programs of **prevention,** as for example, the development of a more comprehensive and dynamic program for the prevention and reduction of **home accidents** and **poisoning** among younger and older persons in Hawaii. The incidence appears to be higher than in mainland communities studied. No immunization procedure, no debatable issues are involved. Forceful and understandable health education of the public, in a way to reach everyone and influence attitudes and personal behavior, is the key. Large dividends await action on this proposal and the others mentioned.

Conducted under the auspices of the Oahu Health Council, Inc., with the cooperation of the Hawaii Department of Health, the University of Hawaii, the Honolulu Chamber of Commerce (which also helped in meeting expenses, as did the Hawaii Heart Association, the Oahu Society for Crippled Children and Adults, and the Oahu Tuberculosis and Health Association), and Survey Advisory Groups on Hawaii, Kauai, Lanai, Maui, Molokai, and Oahu; the State Planning Office, and many others.

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The President's Page



DR. CUSHNIE

"To the wall! To the wall!" as some people cry, is probably all right if they are not the actors who have the part of standing up against the wall or near a ditch—perhaps something calamitous may happen to them. Well, it is not quite that bad, even though we were the actors near the wall during the public hearing on the fee schedule for the Bureau of Workmen's Compensation—a schedule many doctors have worked on long and hard with many meetings and discussions. At the public hearing everything was thrown in, from reasons why we are sorry for ourselves to separating fees for specialists and general practitioners. It appears that labor, industry, and insurance feel (1) The polls we took should be taken again by a third party (perhaps they should); (2) The HMSA fees are the going rate (with this I do not concur). The area of the first and subsequent office calls seems to be the area of objection. Unless the Bureau of Workmen's Compensation comes up with an answer, it will take more discussions and more meetings and maybe more polls. However, I feel the doctors will have to decide before the meetings that we agree among ourselves. I am certain business and labor agree we need a new schedule; it is just a matter of working out a solution in the areas of disagreement.

* * *

Leaning on the above for help in something today, it is obvious in the next question to be discussed—that a public relations man is an important adjunct at such meetings—it may help in bringing together motivated lambs, not motivated tigers.

Well, we have, as you know, been delving into the matter of hiring a PR man to help handle many problems of the doctors and the public, labor, business, and I guess people, as that is the basis of everything the doctors do.

I will come right to the point. The Council of the HMA agrees that we should have a PR man, part-time at this stage, for at least a year. We will take it from there whether he should continue part-time, go on full time, or finish.The President of the Honolulu County Medical Society and his Board of Governors all agree that a PR man is very important to the doctors.

Mr. Hugh Lytle, a PR man, was employed for one month to make a survey of the public relations problems for the Association. His suggestions have been circulated. The Council, at its last meeting, recommended that each county assess its members $15.00 each in order that the program may be put into operation as soon as possible. The HMA cannot raise dues or assess its members without the consent of the House of Delegates, who will not meet until May. Time is an important factor: hence the assessment as a way out for finances in 1961. Your opinions will ultimately be the deciding factor as to whether we have the program.

* * *

The White House Conference on Aging will meet in January to take up the problems facing those over 65. Our Chronic Illness and Aging Committee has done a good job working with the Governor's Interim Commission on Aging in attempting to get a solution for Hawaii. Dr. Shoyei Yamauchi was picked by the Governor to be one of Hawaii's delegates to Washington and I must say that he is the well informed chairman of our Committee. We are aware of the changes of social philosophy and it is not our intention to combat this *per se* but to have it work in other ways than a true welfare state—hence the interest of the committees and doctors.

* * *

The Medical Practice Act has been rewritten in some parts to delete the preceptor method whereby a doctor can get by without the year's residence and in its place substitute a temporary license authorized by the Board of Medical Examiners. There are objections pro and con among the doctors and the legislators, so we will see.

Edward Cushnie



attains
sustains
retains

extra
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activity

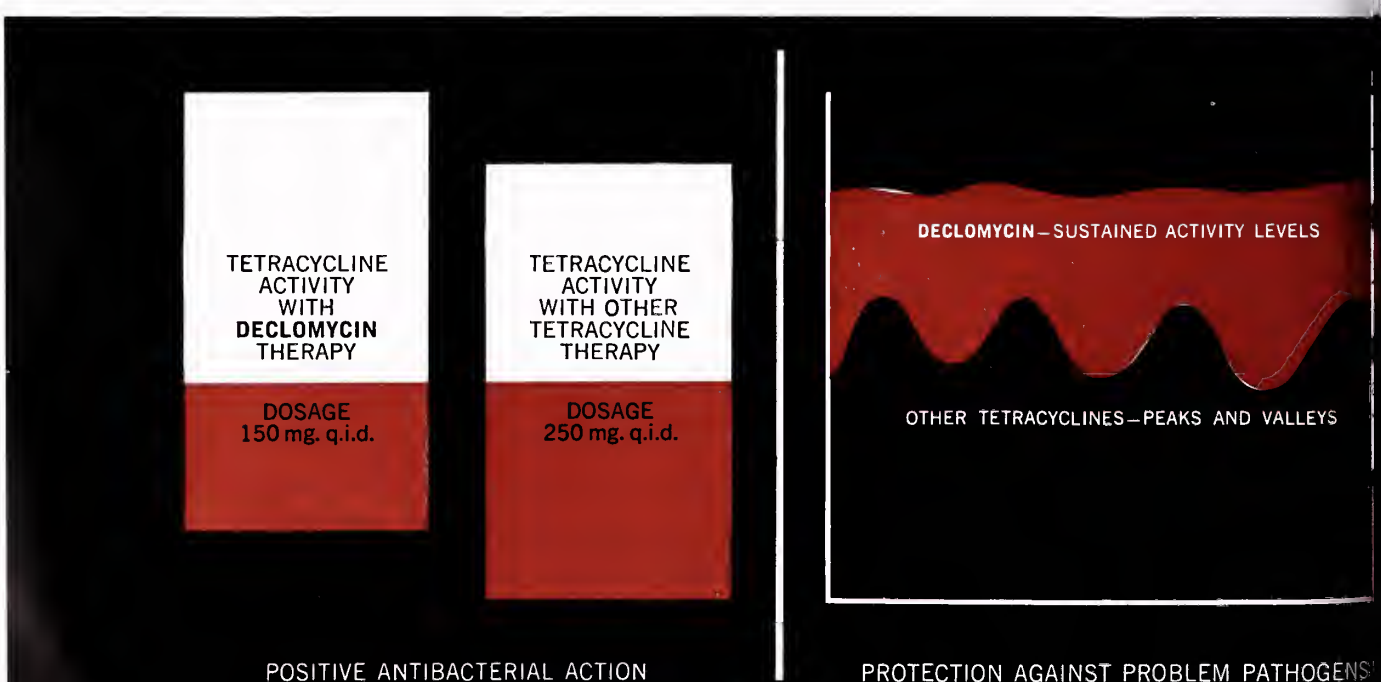
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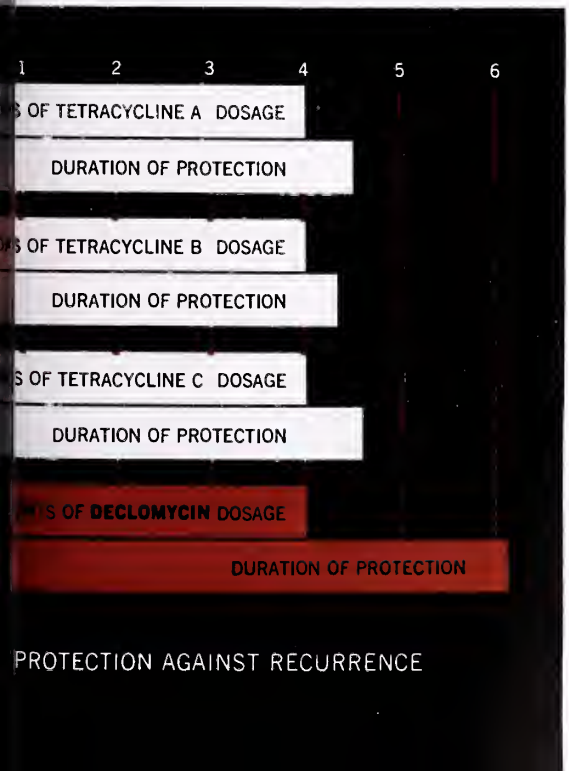


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CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

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[EDITORIALS]

The Foreign Medical Graduate

The Educational Council for Foreign Medical Graduates—the ECFMG—was established in 1957 under the sponsorship of the American Medical Association, the Association of American Medical Colleges, the American Medical Association, and the Federation of State Medical Boards of the United States. It was created because it had become impossible to continue the program of evaluating the quality of medical education in foreign medical schools, as was done by the A.M.A. from 1950 to 1957. The list of "approved" foreign medical schools, which was never a complete one, was officially withdrawn a year ago.

Foreign medical graduates may no longer serve as house physicians, interns, or residents in American hospitals unless they have passed the ECFMG examination—on pain of withdrawal of the offending hospital's accreditation. Exceptions are made in the case of foreign graduates who are licensed to practice medicine in the state; or who are in their final six months of training; or who, though they have failed the last ECFMG examination, are "in worthwhile training programs not involving responsibility for patient care." These last may continue in training through June 30, 1961, if the recommendation of the A.M.A. House of Delegates in Washington last December is accepted by the Joint Commission on Accreditation. "Temporary" certification is given foreign graduates scoring 70-74 on the test; it is given only once, and is valid for two years.

About half the candidates writing this examination in the U.S. and in Canada have passed it; about one-third of those writing it in foreign countries have passed. The test verifies educational credentials and determines the candidate's knowledge of English and his medical knowledge.

It does not, however, solve the problem faced by the foreign graduates themselves. Under Hawaii's Medical Practice Act, most of them are still ineligible for licensure here because they did not graduate from "a medical school or college approved by the Council on Medical Education and Hospitals of the American Medical Association." The only legal alternative to this requirement is to have practiced for ten years as a licensed physician in another jurisdiction.

The withdrawal of the list of approved foreign schools, a year ago, makes it impossible to comply with the existing law. The Council of Medical Education and Hospitals of the AMA and the Executive Council of the Association of American Medical Colleges now recommend that licensing boards consider ECFMG certification as evidence that the recipient has medical knowledge comparable to that expected of graduates of approved U.S. and Canadian schools. Clearly, it is in the interest of the best medical care for the people of Hawaii to admit to practice here the best doctors who apply. The ones we turn away should be the least competent ones, not merely the ones who didn't go to an American or Canadian school.

The Medical Practice Act is now under close scrutiny by a special committee of the Hawaii Medical Association, by the Economic Research Center of the University of Hawaii, and by the Department of Treasury, under which the Board of Medical Examiners has (inappropriately) been placed. It is to be hoped that this study will produce a recommendation to the Legislature for some more reasonable method of screening foreign medical graduates. The ECFMG examination could well serve as a part of this screen.

Our Image

A lot of Americans today like their own doctor but dislike doctors. This is the reasoned opinion of a man named Woodrow Wirsig—former editor of *Woman's Home Companion, Quick,* and *Look,* an associate editor of *Newsweek* and *Ladies' Home Journal,* and currently editor of *Printers' Ink.* He handed it out at the last Southern Medical Association meeting, on a medical economic panel sponsored by the William S. Merrell Company.

Mr. Wirsig says that the public is developing strong resentment toward the medical profession generally. It makes no difference to them that medical services are of excellent quality. They feel that doctors are too impersonal, too distant, too unwilling to explain patients' illnesses in language they can understand. It is this feeling that makes them generally unsympathetic with the doctors' resistance to socialization of medical practice.

This is the "image" of our profession in the minds of a substantial segment of the public. That it may be true of only a handful of doctors is not as important as the fact that it is the image of us all. What matters (in forming public opinion) is not what is so, but what people think is so.

Handsome is (or handsome seems) as handsome does. Individual doctors' reputations, or public "images," correspond to individual doctors' way with patients; what they do, how they do it; what they say, how they say it. If doctors as a group are to improve their public image, they must do more for the public as a group, and do it better; they must say more to the public, and say it better.

Organized medicine in Hawaii is active in the public interest in a dozen ways: the Bureau of Medical Economics, the Medical Practice Committee, the Hawaii Medical Service Association, and others. An important advance in this direction, now pending, is the adoption of the Stockton Plan. We are doing more, and doing it well.

But we need to say more, too, and say it well. It is for this reason that the activation of a Public Policy Committee, with part-time professional Public Relations counsel, has been strongly recommended by the Stevens Committee. Doctor, your endorsement of this recommendation is strongly urged!

The Premarital Examination

". . . no application for a marriage license shall be accepted . . . unless accompanied by a physician's statement . . . that the applicant has . . . been given an examination for syphilis, including a serological test, and is not, in the opinion of such physician, infected with syphilis, or, if so infected, is not, in his opinion, in a state of syphilis which is, or may become, communicable."

—Revised Laws of Hawaii, 1955, Chapter 323-7

The physician performing the examination must sign a statement which reads, in part, "I have examined the person named above and found this person not infected with syphilis or not in a stage which is, or may become, communicable to the married partner. I also certify that I have received and noted the above serological test for syphilis."

The conscientious physician will note that he is required to perform a complete physical examination, including a pelvic examination with speculum —not merely to take a blood test and sign the form if it is negative. Indeed, a positive STS nowadays affords little better than 50% likelihood that the tested person *has* syphilis, so sensitive are the tests and so rare is the disease.

The Hawaii Medical Association's Advisory Committee to the Bureau of Venereal Disease recommended in 1959—and again, though not unanimously, in 1960—that the examination should continue to be required, despite the extremely low discovery rate, partly "as a means of developing rapport between physicians and premarital applicants." Their decision was based in part, in 1960, on the reported rise in the incidence of syphilis in some mainland cities. It was deemed unwise to recommend abolishing even a poor casefinding technique at such a time. It was also pointed out that the cost of performing the tests is so small that no saving would be effected.

In principle, we believe in attending to "unmet needs." Some of these might be supported with more enthusiasm if it appeared that we could stop meeting them when they cease to be needs. This seems to be the case with the premarital examination for syphilis. Just because it is sensible and prudent to have a physical examination before getting married, it does not follow that this should be required by law.

Infant Death Case Study No. 10

A 5 lb. 7 oz. boy was born at approximately eight months gestation, following spontaneous onset of labor and an "easy" delivery, on March 9. There were three prenatal visits, the first on November 25 and the third on March 7. The only problem during pregnancy was a hemoglobin of 11.5 gm, for which the mother was given an iron preparation. Her total weight gain was 16 lbs. STS was negative and Rh was positive. The duration of labor is unknown, and the attending physician has no record regarding the membranes or amniotic fluid. However, the infant was born about an hour after mother's admission to the hospital, and 11 minutes after 50 mg Demerol was given IM. Presentation was cephalic and delivery spontaneous. The infant appeared to be normal. One hour later, however, intermittent cyanosis was noted, and 0.1 cc Nalline was given. Apparently, the cyanosis improved and the infant was described as unremarkable during the next 24 hours. Forty hours after birth, a weak cry and cyanosis were noted. The infant was given oxygen and 1.0 cc Coramine, and transferred to another hospital. (The Coramine was given at 9:25 a.m. and the infant arrived at the other hospital at 11:55 a.m.)

The mother is thought to have had a "cold" with running nose and cough on admission, and 23 hours later was reported to have chills and fever, and more cough. She was given Ilosone, and by the next day was much better. No further diagnosis was made.

On admission to the second hospital, the infant was noted to be hypotonic, dusky in color, and critically ill. The pediatric resident felt that the infant did not look premature, noting particularly the facies and long fingernails. Good bilateral breath sounds with good air exchange were noted, and there were no rales or dullness detected. The heart seemed enlarged; there was no thrill but a grade iii systolic murmur was heard. There was no abdominal organomegaly but bilateral inguinal hernias were noted. The Moro reflex was incomplete and there was no Perez sign. Tentative diagnosis of congenital heart disease, possible cerebral anoxia, and bilateral hernias was made. An x-ray of the chest revealed poor aeration with prominent pulmonary vasculation, interpreted as compatible with congenital heart disease. The infant was placed in oxygen and 5% dextrose in water feedings were started.

Six hours after admission to the second hospital the infant was noted to be less active, cold, face flushed, and the skin was described as "scleremic." The cardiac rate was 180 and the murmur about the same as on admission. There were no rales or rhonchi noted; the liver was not felt to be enlarged. Because of these findings, Solu Cortef 25 mg IM was given and ordered for every 12 hours. Achromycin 30 mg IM every 12 hours was also started and the feedings were stopped. The bilirubin was found at that time to be 6.4 mg (all direct), Hgb 15 gm, and PCV 42%. One hour later the attending pediatrician saw the patient and confirmed all the previous findings, and in addition noted that the liver had descended to the level of the umbilicus. He recommended digitalization and continuation of the previous medications. Digoxin was begun with 0.05 mgs IM every 6 hours. Three hours later the infant was described as somewhat better and pulmonary rales were heard for the first time. Two hours later the baby suddenly expired, 80 hours after birth.

Necropsy Diagnosis: (1) Pan-pneumonitis due to beta hemolytic streptococcus. (2) Bilateral pleural effusion. (3) Prematurity (2,100 gms).

Discussion: Again the matter of specific drugs for resuscitation was discussed. Since Demerol was given 11 minutes before delivery, it is unlikely that Nalline could have affected the baby, and therefore the administration of Nalline was an error in judgment. Coramine also was discussed again, and its narrow margin of safety (see Infant Death Case Study No. 8—HAWAII MEDICAL JOURNAL, Sept.-Oct. 1960).

Indications for the administration of antibiotics were discussed and the following were mentioned: (1) Premature rupture of membranes. (2) Sepsis in mother. (3) Prolonged labor with difficult delivery. (4) Asphyxia, with intubation or mouth-to-mouth resuscitation. (5) Knowledgeable intuition.

Classification: Combined pediatric-obstetrical death; preventable (from a practical point of view). Factors of preventability were error in physician judgment and possibly technic. Factors of responsibility were family physician and hospital (physician and hospital before transfer).

One of a series of case reports prepared by the Advisory Committee to the Bureau of Maternal and Child Health to illustrate the type of study made in the instance of an infant or maternal death in Hawaii.

This is What's New!

The Federation of American Societies for Experimental Biology had among its large membership some of the best scientific brains in the world at this year's joint session on the pharmacological aspects of current social problems. One could hear papers covering everything from the control of biological fertility to molybdenum metabolism. The scientists were optimistic about these problems being within the reach of the human brain.

The problems of the meeting itself were another matter. **Univac I,** the tape digesting computer, was asked to **schedule a meeting** and **prepare an index** in such a way as to "maximize audience satisfaction at a large meeting." "He" worked out such problems as probable attendance, avoiding conflicts, and so forth. Univac did not abstract the articles and probably will not for several years because this "attempts to use the computer to replace the human being rather than supplement him." The Federation Board will report on the practicality of Univac I at a later date (presumably with the assistance of Univac II or III). (*Fed. Proc.* [July] 1960.)

* * *

Beagle milk has about the same composition as milk obtained from other breeds. **Airedales' milk** contains 4.7 per cent less fat than beagles'. The cause remains obscure. (Atomic Energy Commission projects 1, 4 and 6, *Am. J. Physiol.* [Oct.] 1960.)

* * *

Ask the 6-to-16-year-old **problem child** to interpret the proverb, "Two heads are better than one." Worse yet, ask him to illustrate his interpretation with a little sketch. If he produces a two-headed monster, he has a **positive Monster Test,** along with a 90 per cent chance of being psychotic (if he's not pulling your leg?). (*Arch. Gen. Psych.* [Nov.] 1960.)

* * *

The **judicious use of cortisone** is indicated in two major groups of **infectious diseases:** Group 1, with **shock due to bacterial endotoxin** (especially gram-negative organisms) where in spite of a mortality of 60 per cent cortisone contributed to the recovery of some patients; and Group 2, where **severe inflammation complicates** such infections as tuberculosis, mumps, hepatitis, trichinosis as well as drug reactions and rheumatic fever. Eighty-one patients treated at the University of Minnesota fell into the above two groups. The benefits of cortisone far outweighed the possible hazards. (*Ann. Int. Med.* [July] 1960.)

Complete replacement of the mitral valve has been carried out on two patients at the National Heart Institute. The mitral valve is excised and replaced with an open-cell **polymethane foam**—Dacron fabric prosthetic valve. One patient expired 60 hours postoperative because of an artificial chordae tendineae mishap; the other made a slow recovery. (*J. Thor. Cardiov. Surg.* [July] 1960.)

* * *

The concept that the human body, in spite of its remarkable consistency of various organs and fluids, is in a state of **continual flux** has gradually penetrated medical thinking over the past few decades. A heart association investigator reviews the important role of radioisotopes in throwing light on the intricacies of metabolic pools. Most important of all, he points out the methods of design and analysis of isotope experiments—a fascinating business. (*Am. J. Med.* [Nov.] 1960.)

* * *

Bradykinin, a plasma polypeptide, produces all of the symptoms and signs ascribed to crude plasma-kinins; i.e., vasodilatation, fall in blood pressure, increased capillary permeability, contraction of small intestine, bronchoconstriction, and when applied to the base of a blister in man, pain. (*J. Physiol.* 153, 1960.)

* * *

The patient who presents all the signs and symptoms of an **acute abdomen** with a very sudden onset just might have **apoplexy of the lesser omentum.** Two cases—both female—were reported last November. (*Arch. Int. Med.* [Nov.] 1960.)

* * *

Electroconvulsive therapy is **not** good treatment for **intracranial meningioma;** in fact, deterioration after ECT strongly suggests that the psychiatric disorder is secondary to or associated with a brain tumor. Three patients observed at a London neurological hospital had received ECT shortly before the appearance of papilledema and other signs of their tumors. (*Arch. Gen. Psych.* [Nov.] 1960.)

* * *

Amphotericin B was administered to eight patients with disseminated **moniliasis** complicating severe infections and usually associated with large dosages of antibiotics and adrenal steroids. Three of the eight were apparently cured, with the **treatment failing in five.** (*J.A.M.A.* [Sept. 17] 1960.)

FRED I. GILBERT, JR., M.D.

Hawaii Medical Association

Delegate's Report

The Interim Session of the A.M.A. was held in Washington, D. C., November 28-30, 1960.

After much discussion and over stiff objections, it was agreed we should give the AMA dues their first boost in ten years: $10 a year more in 1962 and another $10 in 1963. This would finance, among other things:

1. Financial aid to medical students.
2. Continuing medical education for practicing physicians.
3. Health education of the public.
4. Medical research.
5. Expansion of our public relations program.

The Trustees were directed to immediately take the lead in consolidating efforts by the AMA, the American Hospital Association, the Blue Shield, and the Blue Cross in maximum development, on a national scale, of the voluntary prepayment concept—with the assistance of representatives of commercial insurance carriers, other professional groups, and representatives of industry, labor, and the public at large.

Among lesser actions, the Delegates:

Approved redefinition of the functions of the Council on Medical Education and Hospitals.

Refused to approve a 1956 action approving the practice of medicine by medical school faculty members.

Approved a guide for continuing medical education programs.

Approved a Trustees' report informing the House of relaxed hospital accreditation requirements.

Adopted a combined student honors (scholarship) program and a student loan program.

Approved retention of foreign graduates who have not passed the ECFMG examination in worthwhile training programs not involving responsibility for patient care through June 30, 1961. A plea to let them complete training programs through July 1, 1963, was rejected.

Asked the Council on Medical Education and Hospitals to establish liaison with local residency review committees.

Asked the National Intern Matching Program to reconsider its decision to appoint foreign medical graduates under the Program by 1962.

Encouraged state and county medical societies to encourage high school scholarship award programs.

Reaffirmed support of the Kerr-Mills Act and opposition to use of the OASDI mechanism for medical aid to the aged.

Referred to the Trustees an Oregon resolution asking for a long-range planning board to study trends affecting medical practice and health services.

Encouraged nonpartisan political activity on a national, state and local level, and approved the "key man"

(Continued on page 280)

MINUTES OF THE COUNCIL MEETING

December 13, 1960, at 6:00 P.M.
Ciro's, Honolulu

PRESENT

Dr. Edward F. Cushnie, presiding; Drs. Burden, Giles, Nishigaya, Nishijima, and West plus Dr. William Stevens. Dr. A. S. Hartwell was seated in place of Dr. Benson and Dr. K. Izumi was seated in place of Dr. Fleming.

MINUTES

The minutes of the August 16, 1960, meeting were approved as published.

WHITE HOUSE CONFERENCE ON AGING

Dr. Cushnie advised the Council that we were unable to get a second physician appointed as delegate to the White House Conference on Aging, even though funds had been appropriated to cover his expenses. In the meantime, a request has been received from the Interim Commission on Aging for funds to help defray the expenses of sending delegates to Washington. The state and federal funds available are not sufficient to cover all the delegates named and so the Commission has had to appeal to the community for support. Contributions have been acquired from several of the endowment trusts but the Commission is still $1,000 short of its goal.

ACTION:

It was moved and seconded that we appropriate the money, $645.00, to send a delegate to the White House Conference on Aging. The motion passed unanimously.

HAWAIIAN SCIENCE FAIR

It was noted that our representative to the Hawaii Academy of Science, Dr. W. H. Civin, felt that the prizes and contribution given in the past would be sufficient for 1961.

ACTION:

It was moved and seconded that the amount ($150) appropriated to the Hawaiian Science Fair remain unchanged in 1960. The motion passed unanimously.

AAPS ESSAY CONTEST

The members of the Council felt that more publicity should be given to this contest and suggested that the Chairman of the Public Relations Committee get in touch with the presidents of the county societies. It was also suggested that a report be obtained on the number of essays submitted to each county and an effort be made to develop increased interest. Dr. Hartwell said that Honolulu had budgeted for this project.

ACTION:

It was moved and seconded that the same prizes ($175) be given in 1961 as in previous years. The motion passed unanimously.

UNIVERSITY OF HAWAII INSTITUTE OF HEALTH RESEARCH

Dr. Cushnie advised that he had received a letter from the president of the University asking that a physician be appointed to his advisory board which will assist the director and the University in guiding the program which is financed by the State of Hawaii and the National Institutes of Health. Dr. Arnold's name had been suggested for this appointment.

(Continued on page 280)

Notes and News

Travel News

Seen at the American Academy of Pediatrics meeting in Chicago were **Drs. T. Yoshina, Joseph Palma, George Ewing, Frances Nakamura,** and **Donald Marshall.** Also in attendance and in demand was **Dr. Ralph Platou,** recent visiting professor at Children's.

Dr. Sanford Katsuki revisited the scenes of his old school days in North Dakota and reports "good eating." He gained ten pounds, and is now paying the consequences. **Dr. Harold Kimata** hurried home from Chicago in one day to make a dinner engagement. **Dr. and Mrs. H. Q. Pang** recently made rounds of a few Pacific Coast cities. Surgery on his ear somewhat curtailed H.Q.'s activities.

Our traveling Director of the Health Department, **Dr. Richard K. C. Lee,** was off to San Francisco to attend the annual meetings of the State Health Officers and the American Public Health Association. Dr. Lee has been honored by being one of 62 recipients of the Chas. Pfizer & Co., Inc., merit award for outstanding contribution to the nonmilitary defense effort of the nation. **Dr. Richard You** attended the AAU meeting in Las Vegas and went on to Washington, D. C., to represent the Hawaii Medical Association at the Second National Conference on the Medical Aspects of Sports. **Dr. Linus C. Pauling, Jr.,** represented the Mental Health Association at the 10th Annual Assembly of the National Association of Mental Health in Denver.

In Manila for the International Congress of Ophthalmologists-Asia-Pacific Academy was **Dr. W. J. Holmes. Dr. and Mrs. Edward Lau** report a wonderful around-the-world trip in August. **Dr. and Mrs. H. B. Luke** made an extended trip to southeast Asia. **Dr. and Mrs. Charles Judd** and family spent three exciting months in Japan. Some of their experiences were recounted in the local papers. **Dr. Mary A. Glover,** on a mercy mission to Indonesia on the SS "Hope," reports periodically in *The Advertiser.*

New Affiliations

Dr. J. K. Ikeda has moved to 2229 No. School St. **Dr. Vernon G. Boido** has severed connections as plantation physician and has opened offices at the Koloa Dispensary on Kauai. **Dr. Ted Tomita** has relocated in a new building at the Waipahu Professional Center Building. **Dr. Edward Y. Yamada,** former G.P., has returned from postgraduate training and has located himself again in Kainuki. He is an internist. **Dr. Arno J. Mundt** has joined the Fronk Clinic as obstetrician.

Named in the News

The medical profession suffered a great loss with the sudden death of **Dr. Tell Nelson.** In practice in Hawaii since the war, Tell was respected and loved by all. He contributed greatly to the medical profession with his knowledge and experience in allergy.

Also shocking to the profession was the death of **Dr. Eichi Masunaga** of Hanapepe, Kauai. He passed away after a prolonged illness following surgery.

Dr. Robert R. Simpson made news in the local papers when he sadly learned that his head was much softer than a surfboard. Stitches to a six-inch scalp wound convinced him.

Dr. I. Katsuki, father of **Drs. David, Sanford,** and **Robert,** recently celebrated his 96th birthday with his usual walk of four blocks to catch a bus for Waikiki to have lunch.

Dr. William Stevens' experiences with the use of LSD-25 (lysergic acid diethylamide) made news lately, much to the distress of his fellow psychiatrists.

The Mental Health Association, in a letter signed by **Dr. Linus C. Pauling, Jr.,** indirectly supported Warden Joe C. Harper in his dispute with Social Service Director Mary C. Noonan over Oahu Prison administration. **Dr. Clarence Fronk's** horse, Pi-nao, was crowned grand champion at the Hawaii Rodeo Cowboy Association's Sho-De-O.

The diabetes detection campaign headed by **Dr. Donald Brown** gave 1,058 free tests—8.5% showed higher than normal blood levels. Recent question on euthanasia as reported by a local paper, shows doctors getting par for the course. Headline, "Island Doctors Don't Agree on Care of the Fatally Ill."

Many Honolulu physicians were shocked to read of **Dr. Sumner Price's** resignation as administrator of Queen's. Few know the details.

Local physicians were happy to see **Dr. Charles Wilbar,** Pennsylvania's Director of Health and former chief of the local Health Department, on his first trip back in seven years. He made the headlines by attacking Hawaii's fluoridation record. Ex-Korean ambassador and ex-Honolulu medico, **Dr. Y. C. Yang,** has begun a new career in Washington, D. C.

Dr. and Mrs. Albert Ishii recently honored Republican county boss, Ben Dillingham, at cocktails.

Dr. and Mrs. Leo L. Sexton celebrated their golden wedding anniversary last October. He was the second intern at The Queen's Hospital and is the father of **Dr. Harold M. Sexton.**

Honolulu County Medical Society made headlines by approving in principle the so-called Stockton Plan. The Medical Care Plans Committee is now working out the details for approval.

Dr. Masato Hasegawa was mentioned in the society columns at the recent Nixon-For-President get-together sponsored by the ladies.

Local hospitals employing foreign medical graduates can take a bow—15 of the 17 taking the recent ECMFG examination, testing their qualifications by our standards, passed.

Congratulations

Dr. R. T. Wong was elected President of the Hawaii Chapter of the American College of Surgeons at its annual meeting. New directors are **Drs. Ed Lau** and **Robert A. Rose** of Honolulu and **Dr. F. C. Wong** of Hilo.

Dr. H. Q. Pang sports a beautiful plaque for his devoted services as President of the Honolulu County Medical Society. It was presented by the new President, **Dr. A. S. Hartwell.** Formally installed, an innovation at the HCMS annual meeting, were **Drs. A. S. Hartwell,** President; **O. D. Pinkerton,** President-elect; **Richard D. Moore,** Secretary; and **T. T. Tomita,** Treasurer. Congratulations!

Congratulations to **Dr. Richard Ando,** proud father of a new son born November 4, and also for receiving a certificate as a parliamentarian. He is the fifth physician in the U.S. to pass these boards.

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In Memoriam -- Doctors of Hawaii -- XXX

This is the thirtieth installment of In Memoriam —Doctors of Hawaii.

William Osmers

William Osmers was born in Bremen, Germany, December 17, 1874, while his parents were on a visit there. When he was seven months old, they returned to their home in San Francisco, California



DR. OSMERS

His father, Charles Osmers, was a naturalized citizen of the state of California. His mother was Anna Osmers.

He attended Lowell High School in San Francisco and Cooper Medical College (now a part of Stanford University), graduating in June, 1900. He majored in surgery and diseases of the heart. Dr. Osmers went abroad to do postgraduate work.

On his return, he opened an office on Post Street, near Union Square, but not for long—the San Francisco earthquake of April, 1906, leveled the city—and with it went business and all. During this ordeal, he was offered a position at The Queen's Hospital, which he accepted. Then one day in August, 1906, he sailed for Hawaii on the "Mongolia," which went aground off Waimanalo, near Rabbit Island.

When his contract with Queen's was at an end, he went to Kauai to substitute for Dr. Kuhns (it is believed). While there he was appointed government physician and agent for the Territorial Board of Health on June 20, 1908, and again on July 15, 1908.

After leaving Kauai, he went over to Hilo, Hawaii, for six months to substitute for Dr. John J. Grace (December 31, 1908, to July 1, 1909).

In 1909 Dr. Osmers went to Maui to substitute for Dr. Sawyer, then on leave. Dr. Sawyer was the doctor in charge of Puunene Hospital. After leaving Puunene Hospital, Dr. Osmers was appointed plantation physician for Wailuku Sugar Company and served for 37 years until his retirement on July 1, 1946.

He was appointed government physician and agent of the Board of Health in the District of Wailuku, Maui, on September 1, 1909, which position he also held until he retired. He was superintendent of Malulani Hospital in which capacity he served for 20 years. From May 18, 1917, to March 31, 1919, he served on the Medical Advisory Board of the County of Maui. Up until the time he retired, Dr. Osmers was United States Surgeon of Ports in Kahului, Maui.

Dr. Osmers' war work was confined to the frontlines at home.

On September 24, 1919, Dr. Osmers married Miss Emma Harriet Napoleon. The service was performed by Dr. John L. Hopwood of Mid-Pacific Institute.

The doctor was interested in Boy Scout work, First Aid, Crippled Children, the Salvation Army, and church work.

Dr. Osmers died March 18, 1950, at Malulani Hospital at Wailuku, Maui, at the age of 75.

He was a life member of Aloha Lodge No. 3, Knights of Pythias Hawaii, Free and Accepted Masons of California, Maui Lodge No. 432, Maui Consistory, Maui Shrine Club, Aloha Temple, Honolulu Lodge No. 616 B.P.O. Elks (member for 29 years). He was a member of the Maui Chamber of Commerce, Maui Fair and Racing Association, Alpha Kappa Kappa fraternity (Beta Xi chapter), Maui Medical Society, American Medical Association, Medical Veterans of the World War, American National Red Cross, Boy Scouts of America (20 years' veteran and Silver Bear holder), American Association of Industrial Physicians and Surgeons (honorary membership), and the Association of Military Surgeons of the United States (Captain in the Medical Corps—Hawaii National Guard).

MRS. WILLIAM OSMERS

John Hogan Farrell

John Hogan Farrell was born October 4, 1882, in Winthrop, Iowa. He was the son of Thomas and Mary (Hogan) Farrell.

His education was received at Winthrop High School, after which he attended the University of Iowa College of Pharmacy 1902, the University of Iowa 1903 and was granted his medical degree from the University of Illinois in 1907. In 1910 he took postgraduate work at Chicago Eye, Ear, Nose and Throat College.

Dr. Farrell interned at Roosevelt Hospital, Chicago, in 1906-1907. He also served on the staff at Municipal Hospital in the same city.

Coming to the Islands, he practiced at Wailuku, Maui, from 1907-1911. On February 1, 1911, Dr. Farrell moved to Honolulu where he specialized in eye, ear, nose, and throat cases until 1942 when he went to California. He continued his practice in Redwood City, California, until his retirement in 1946.

Dr. Farrell died July 10, 1955, in Atherton, California, at the age of 72.

He was a member of the American Medical Association, Sigma Phi Epsilon and Honolulu Elks Lodge No. 616.

Herbert Piercy Nottage

Herbert Piercy Nottage was born in Chelsea, Massachusetts, in 1867, the son of Samuel F. and Mary Francis (Hamlin) Nottage.

He graduated from Harvard Medical School in 1886.

Dr. Nottage married Hattie May Hastings. The couple had two sons, Piercy Hastings and Nathaniel.

Before coming to Hawaii, Dr. Nottage practiced in Massachusetts and California. In 1907 he came to Honolulu where he was associated with Dr. Rodgers as an eye, ear, nose and throat specialist. Later he opened his own office.

During World War I, Dr. Nottage served as an officer.

Leaving Honolulu in 1914 for China, the doctor practiced and taught in Canton Christian College for ten years. In 1924 Dr. Nottage returned to California where he practiced in Ventura and later in Ontario.

Dr. Nottage died in Ontario, California, September 15, 1939, shortly after retiring from active practice. He was 72 at the time of his death.

He was a member of the California Medical Association.

County Society Reports

Kauai

The regular monthly meeting of the Kauai County Medical Society was held on Tuesday, November 1, 1960, at the Wilcox Memorial Hospital Library.

Miss Anne Isonaga, representative of the County of Kauai for medical care of county pensioners, attended the meeting. She stated that Chapter 6, Section 4, of Revision of State Laws, 1955, indicates that the medical care of county pensioners is the responsibility of the government physician. Her decision as to when a person is considered a medical indigent by her department was explained. A discussion brought out the fact that Hawaii, Maui, and Oahu pay a salary to a physician or physicians to take care of these cases; whereas on Kauai there is no such arrangement. The President appointed a committee consisting of Drs. Boyden, Boido, and Brennecke to study the problem with the aid of an attorney, and to present a possible solution to the Society as a whole.

In a discussion of Mr. Kennedy's letter, dated September 15, 1960, about the visits of Drs. Fraser and Cope as part of the post-graduate lecture series, it was decided to ask these doctors to come on separate nights, preferably, Friday or Monday night instead of Saturday night during the month of February.

The film from Eli Lilly "Cancer Detection and Examination" was shown. Dr. Grover Batten, representing the American Cancer Society, spoke on the present status of the plans for establishing the Registry of Neoplasms.

* * *

A special meeting was held at Kauai Inn on Friday, November 4, with The Advisory Committee to the Bureau of Maternal and Child Health.

The following doctors were present—Wallis, Boido, Kuhns, Goodhue, Boyden, Fujii, Wade, Ishii, and Brennecke. Dr. Garcia was a guest of Dr. Wallis.

Dr. Allan Oglesby, Colonel Fairchild, Dr. Goto, Dr. Edgar, Dr. and Mrs. Bowles, Dr. Haake, Colonel Zimmermann, Commander Drips, and Dr. Hanley, represented The Advisory Committee to the Bureau of Maternal and Child Health.

MARVIN A. BRENNECKE, M.D.
Secretary

Hawaii

The Hawaii County Medical Society held its monthly meeting on September 22, 1960 at the Naniloa Hotel. Guests present were Drs. Moran, Graumann, and Mr. Vance.

Dr. Hata announced that the University of Hawaii Scholarship Committee chose Mr. Rodney Yamaoka as recipient of the Hawaii County Medical Society Scholarship of $300.00.

Dr. Hata stated that in February, 1961, the Honolulu County Medical Society is inviting Dr. Oliver Cope and Dr. Frazer to Honolulu to talk on "Endocrinology from the Medical and Surgical Aspect." A motion was made by Dr. Haraguchi to invite these doctors over to Hilo to speak to our Society also. The motion was seconded by Dr. Mitchel, and carried.

The members voted not to buy the AMA Medical Directory this year.

The scientific session of the evening consisted of a survey and analysis of the recent tidal wave casualties in Hilo. Interesting medical and surgical cases were presented and discussed. Participants in the program were Doctors Wipperman, Mitchel, Taniguchi, M. L. Chang, Musser, Helms, and Mr. Vance.

* * *

The October 25, 1960, meeting of the Hawaii County Medical Society was held at the Naniloa Hotel. Eighteen members were present.

Dr. Hata read a letter received from Mr. Rodney Yamaoka, thanking the Society for the $300.00 scholarship to the University of Hawaii, Hilo Campus. This was the first year the Medical Society offered the scholarship. Also, a letter from Mr. Yarberry of the University of Hawaii, was read, acknowledging receipt and thanking the Society for the scholarship money.

The proposed new fee schedule of the Workmen's Compensation, as worked out by the Honolulu County Medical Society, was reviewed. Dr. Haraguchi made a motion to accept the new fee schedule. This was seconded by Dr. Bergin, and passed unanimously.

Following the business meeting, Dr. Conde Conroy, Professor of Surgery at Marquette Medical School, gave an informative lecture on "Massive Gastric Hemorrhage and Its Treatment." The lecture was augmented by Dr. Louis Kretchmar, Instructor in Surgery at Marquette, who spoke on the role of vagotomy and gastric resection.

* * *

The Hawaii County Medical Society held its monthly meeting on November 17, 1960, at the Hilo Hotel. Guests present were Bockrath and Goldenberg and Mr. Dalbec.

Dr. Yonemichi Miyashiro's application for membership in the Hawaii County Medical Society was approved by the Credential Committee. Dr. Loo made the motion to accept him into the Society. This was seconded by Dr. Okumoto and carried unanimously.

Dr. Wipperman returned from a meeting in Honolulu, and made a report on the proposed Foundation Plan (Stockton Plan) of medical insurance.

Following the business meeting, Dr. Martin Goldenberg, research microbiologist with the State Department of Health, gave an informative talk on "Medical effects of Atomic, Biological, and Chemical Warfare." The talk was supplemented with a moving picture.

The second part of the scientific session consisted of a movie entitled "Resuscitation of the Newborn."

The remainder of the evening was taken up by Mr. Reuben Dalbec, field representative of the AMA, who discussed informally various subjects including the For-and Bill, Social Security, and volunteer health insurance.

TOKUSO TANIGUCHI, M.D.
Secretary

Maui

A dinner meeting of the Maui County Medical Society was held at 6:30 P.M. on Tuesday, October 25, 1960 at the Wailuku Hotel.

Guests present were: Miss Mary Noonan, Dr. J. Wallis, Mr. Francis Ishida, Mr. Bud Uyenoyama, and Mr. Tomic T. Romson.

Miss Mary Noonan, head of the Department of Social Services, was introduced as the guest speaker. She

(Continued on page 297)

Book Reviews

iseases of the Newborn

y Alexander J. Schaffer, M.D., 878 pp., $20.00, W. B. Saunders Co., 1960.

The book, although written by a pediatrician undoubtedly for pediatricians, is highly recommended for practitioners in all fields, more so for the general practioner looking for some text presenting practically all nditions arising in the newborn with excellent discusns of each normal or pathological condition, briefly it concisely described omitting lengthy details, statistics, and specifics.

Each subject is discussed as to incidence, etiology, agnosis, prognosis, and treatment, allowing the practioner to seek details in other specialized texts elaborating each condition in any category if he so desires.

The book is profusely illustrated with excellent biographies at the conclusion of each subject.

CLARENCE F. CHANG, M.D.

Complications of Pregnancy

y The Staff of the Mount Sinai Hospital, Edited by Alan F. Guttmacher, M.D., and Joseph J. Rovinsky, M.D., 619 pp., $16.50, The Williams and Wilkins Company, 1960.

This book does not replace the skilled and experienced nsultant in the various specialties, but it serves as up-to-date supplement to his advice. I have found is book so interesting from cover to cover and so full up-to-the-minute information gleaned from a vast nount of recent medical literature that I find it difult to put it down to attend to my routine duties. hose of us specializing in the obstetrical field will find of tremendous value in giving advice when we are lled as consultants.

The physician who requests the consultation, whether be a specialist himself or in general practice, will id the book of inestimable help both before and after e consultation.

H. E. BOWLES, M.D.

Intra-osseous Venography

y Robert A. Schobinger, M.D., 243 pp., $14.50, Grune & Stratton, 1960.

This is an excellent atlas type monograph on a phase f diagnostic medicine which is seldom used by the verage physician. Although the author did not discover tra-osseous venography, he has extended its use and ustrated its value in multiple new areas. Most physians would not use this procedure of diagnosis, prarily because of a lack of training or knowledge of its lue. This monograph is delightfully complete in that illustrates the technical procedure required to obtain proper examination, and with a minimal amount of mplicated technique or apparatus.

After discussing the technique, the book is broken wn into sections, which amounts to venography of rious portions of the body. Many of the areas can- t be studied in any other manner. He has multiple ustrations of both the normal and abnormal. Perhaps vo of the most valuable would be visualization of the internal mammary venous system, and azygos system, to evaluate morbid conditions in these areas, particularly metastatic disease, that are not manifested by the usual studies.

The second portion that will perhaps be highly useful deals with visualization of the venous system of the lower extremities. Venography here is already well known and fairly widely used in selected cases. There are patients where an accessible vein cannot be found in the foot and ankle region, and this technique permits visualization of these veins via the osseous route.

The book is recommended to all radiologists, all surgeons, and other physicians interested in diagnostic investigation of not only the vascular and venous system, but neoplastic investigation in general.

GEORGE W. HENRY, M.D.

★Current Therapy, 12th Ed.

Edited by Howard F. Conn, M.D., 808 pp., $12.00, W. B. Saunders Company, 1960.

Current Therapy—1960, written by several hundred contributors, is an authoritative, detailed, and unbiased source of information about presently available medications, procedures, and concepts of treatment.

In these days of intensive medical research, the physician may feel overwhelmed by the flood of medical literature crossing his desk. Amid the claims and counterclaims of manufacturers and their sales machinations, he may have difficulty in selecting the proper therapeutic agents. Many new preparations are specific and sufficiently potent to require careful administration of exact dosages, and close observation of the patient, often for side effects which the physician may not have yet encountered.

Assuming that the physician has made an accurate diagnosis, he thus may wish for unbiased information about effective therapy, the uses of the most potent preparations, side effects, and the expected response of the patient. Here he has it. In this book, each author concisely and skillfully describes the diseases he best knows, realistically stating what may be expected as treatment continues.

Indexed by diseases, symptoms, organs, and drugs, this book is easily used as a quick reference. It contains excellent dosage tables, lists of physiologic normals, and a particularly complete description of the active ingredients in about 650 household products.

This is an outstanding volume, an excellent companion piece for Goodman and Gilman.

FRANK L. TABRAH, M.D.

Also Received

★Handbook of Medical Treatment, 17th Ed.

By M. J. Chatton, M.D., S. Margen, M.A., M.D., and Henry Brainerd, M.D., 568 pp., $3.50, Lange Medical Publications, 1960.

The complimentary foreword by William J. Kerr indicates that this seventh edition, in 11 years, is worth owning. The University of California faculty collaborated in its preparation.

★ Highly recommended.

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Now available for use in your practice from The Wesson People . . . easy-to-use manual of 40 pages, including all necessary diet instructions . . . menus, recipes, shopping and cooking guidance . . . all worked out for you . . . so arranged and printed that you have only to check the desired daily calorie level before giving the book to your patient.

You will find this book invaluable for treating patients with elevated serum cholesterol.

Complete menus for 10 days enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

NRC Standards fulfilled. Each menu has been calculated to provide the proper daily allowance of proteins, vitamins and other nutrients as recommended by the Food and Nutrition Board of the National Research Council.

Weight control is achieved as each day's menu is given at 3 calorie levels—1200, 1800 and 2600 calories. You prescribe the level most desirable and modify as desired.

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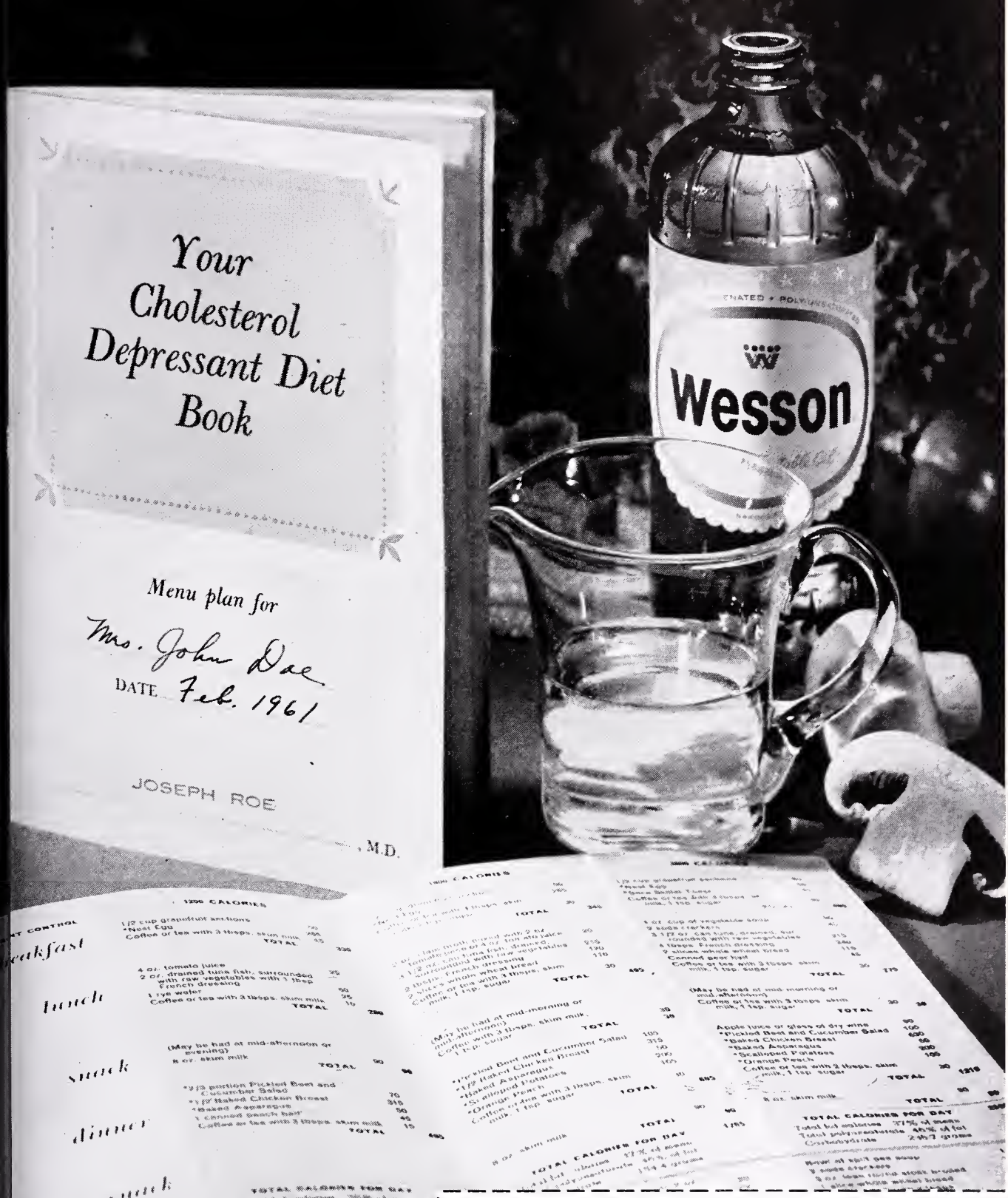
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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Hawaii Nurses Association

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BYLAWS
of
Hawaii Nurses Association

(as Revised October 22, 1960)

ARTICLE I—Title and Functions

Section 1. The name of this association shall be Hawaii Nurses Association.

Section 2. The functions of the Hawaii Nurses Association shall include the following:

(a) To assist the American Nurses' Association in defining functions of nurses and improving standards of practice of professional nurses.

(b) To assist the Hawaii Nurses Association in defining qualifications for the practitioners of nursing.

(c) To promote legislation and to speak for nurses in regard to legislative action concerning general health and welfare programs.

(d) To survey periodically the nurse resources of the state.

(e) To promote and protect the economic and general welfare of nurses.

(f) To interpret and promote professional counseling and placement service to nurses and employers.

(g) To develop and promise actively a program for intergroup relations.

(h) To cooperate with the Hawaii League for Nursing in activities which concern both organizations.

(i) To represent nurses and serve as their state spokesman with allied professional and government groups and with the public.

(j) To establish standards for nurses professional registries and approve registries which meet state standards.

ARTICLE II—Constituent Associations

Section 1. District nurses' associations which have been or which hereafter may be organized, whose constitution and bylaws are in harmony with the bylaws of this association and have been approved by majority vote of the board of directors of the association, shall be recognized as constituent associations of the Hawaii Nurses Association.

Section 2. The boundaries of the district nurses' associations shall be clearly defined and recorded by the board of directors of this association. The boundaries may be changed by two-thirds vote of the board of directors of this association, provided such change has been approved by each district nurses' association involved.

Section 3. A district nurses' association which fails to comply with the requirements of those bylaws, or for other causes deemed sufficient, may be disqualified as a constituent association of the Hawaii Nurses Association by unanimous vote of the board of directors, provided due notice has been given the district nurses' association at least three months before the vote is taken.

Section 4. A district nurses' association which has been disqualified may be reinstated by unanimous vote of the board of directors.

ARTICLE III—Membership

Section 1. The membership of this association shall consist of the active and associate members of the constituent associations.

Members of district nurses' associations shall be nurses who are graduates of state accredited schools of professional nursing offering programs of not less than two years of instruction and clinical practice in hospitals and in other community agencies, each of whom has been granted a license to practice as a registered nurse in at least one state, which license has not been revoked in any state for professional misconduct.

Section 2. The active members of this association shall be the active members of the constituent associations and shall have all privileges of membership. Only active members shall have the privileges of voting in sections and serving as delegates at meetings of this association and the American Nurses' Association. Only active members shall be eligible to hold office and to serve as chairmen of standing committees.

Section 3. The associate members of this association shall be the associate members of the constituent associations. Only members who do not anticipate employment in nursing during the current calendar year may be associate members. Upon such employment, associate members shall be required to transfer to active membership, failing which they shall forfeit the rights of associate membership and be stricken from the rolls by the constituent association of which they are members.

Associate members shall have all of the privileges of membership except those of voting, serving as delegates, holding office or serving as chairmen of standing committees. No member or applicant for membership shall be required to become an associate member if active membership is preferred.

Section 4. The presentation to this association of a classified typewritten list of members in good standing in the district nurses' association, signed by the secretaries of those associations, together with the annual dues of such members, shall establish such members of constituent nurses' associations as members of this association.

Section 5. Every member in good standing in the Hawaii Nurses Association is a member of the American Nurses' Association and every member has representation through that association in the International Council of Nurses.

Section 6. A member of another constituent association of the American Nurses' Association who moves to this state may transfer membership to this association without further payment of dues for the remainder of the fiscal year, provided such nurse meets the requirements for membership in this association and the request for transfer of membership is accepted. The request for transfer shall be sent to the executive secretary of the state nurses' association issuing the transfer.

A member of this association who moves out of this state may apply to the secretary of this association for transfer of membership to the state nurses' association of the state of new residence.

Section 7. A member may transfer from one district nurses' association to another within the state without further payment of dues for the remainder of the fiscal year, provided such nurse meets the requirements for membership of the association in the new district and the request for transfer of membership is accepted by that association. Application for transfer of membership shall be made to the secretary of the district nurses' association of which the nurse is currently a member.

Section 8. Honorary recognition may be conferred by a unanimous vote at any annual convention on persons who have rendered distinguished service or valuable assistance to the nursing profession, the name or names having been recommended by the board of directors. Honorary recognition shall not be conferred on more than two persons at any annual convention.

ARTICLE IV—Dues

Section 1. (a) The annual dues to this association shall be thirty dollars and fifty cents ($30.50) per capita for active members, payable on or before February 10 by the constituent associations, which includes seven dollars and fifty cents ($7.50) per capita dues to the American Nurses' Association.

(b) The annual dues for associate members of this association shall be seven dollars ($7.00) per capita, payable on or before February 10 by the constituent associations, which includes two dollars ($2.00) per capita dues to the American Nurses' Association.

Dues for associate members who become active members during the fiscal year and who have paid dues as associate members for that year shall be twenty-three dollars and fifty cents ($23.50) in addition to the seven dollars ($7.00) previously paid. From the amount twenty-three dollars and fifty cents ($23.50) paid in, five dollars and fifty cents ($5.50) will be sent to the American Nurses' Association.

(c) The dues for nurses who graduate and are licensed to practice professional nursing after July 1 of any year and become active members of this association shall be fifteen dollars and twenty-five cents ($15.25) per capita, for that same year, and payable by the constituent association which includes three dollars and seventy-five cents ($3.75) per capita dues to the American Nurses' Association.

Section 2. Dues received by district nurses' associations after February 10 shall be paid monthly to this association during the remainder of the year.

Section 3. District nurses' associations which have not paid dues for any members to this association by March 15 shall be notified by the treasurer, and those which have paid no dues by April 15 shall be disqualified as constituent associations of the Hawaii Nurses Association.

Section 4. Not later than March 15 the treasurer of this association shall pay to the American Nurses' Association seven dollars and fifty cents ($7.50) per capita for the active membership and two dollars ($2.00) per capita for the associate members of this association for the current calendar year.

Section 5. Dues received by this association after March 15 shall be paid to the American Nurses' Association monthly during the remainder of this year.

Section 6. All dues paid to the American Nurses' Association shall be accompanied by a typewritten classified list of the members for whom dues are paid.

ARTICLE V—Officers

Section 1. The officers of this association shall be a president, a first vice-president, a second vice-president, a secretary, a treasurer and six (6) directors.

Section 2. Officers shall be elected at annual conventions as hereinafter provided.

Section 3. Officers shall perform the duties usually performed by such officers and also such duties as are specified in these bylaws and designated by the board of directors of this association.

Section 4. Vacancies in office shall be filled as hereinafter provided.

Section 5. No officer shall serve more than two (2) successive terms in the same office. Service for a portion of the term greater than half shall be considered a term.

Section 6. No person shall be elected to serve as an officer or director of this association, who at the same time, would be serving as a section chairman.

ARTICLE VI—Duties of Officers

Section 1. (a) The president shall preside at all meetings of this association and all meetings of the board of directors and be a member ex-officio of all committees except the Committee on Nominations.

(b) The president shall deliver an annual address and perform all duties of the office.

(c) The president or her alternate shall serve as a representative of the association at meetings of the Advisory Council of the American Nurses' Association.

(d) In the even years the president shall serve as chairman of the Coordinating Council of the Hawaii Nurses Association and the Hawaii League for Nursing.

(e) The president shall be empowered to appoint all standing and special committees, except Nomination Committee, of the association with the approval of the board of directors.

Section 2. In the absence of the president, the vice-presidents in order of rank shall assume the duties of the president. They shall also assume other duties as assigned to them by the board of directors. In the event of a vacancy occurring in the office of president, the first vice-president shall assume the duties of president until the next annual convention or until a successor is elected. In the event of a vacancy occurring in the office of first vice-president, the second vice-president shall assume the duties of the first vice-president until the next annual convention or until a successor is elected. The first vice-president shall be a member ex-officio of the Committee on Constitution and Bylaws.

Section 3. The duties of the second vice-president shall be the same as those of the first vice-president and she shall serve as temporary parliamentarian in the absence of the first vice-president. She shall be a member ex-officio of the Committee on Nursing Information and Membership.

Section 4. (a) The secretary shall be responsible to keep minutes of all meetings of this association, and the board of directors.

(b) She shall be the custodian of the seal of this corporation and the permanent files of same.

(c) She shall be a member ex-officio of the Committee on Nominations.

(d) She shall prepare and deliver to the annual convention of this association, a report on the accomplishments of this association during the preceding calendar year.

(e) She shall deliver to her successor within one month after her election to office all records and the seal of this association.

(f) She shall notify all officers, directors and committees of election or appointment; send notices of the time and place of all meetings; send to the secretary of the American Nurses' Association the names and addresses of all officers of the Hawaii Nurses Association immediately after their election.

(g) Conduct the general correspondence of the association and the board of directors.

(h) She shall keep a correct list of the names and addresses of all members of this association.

The executive secretary shall assume such duties in connection with the work of the secretary as shall be designated by the board of directors.

Section 5. (a) The treasurer shall receive and have charge of all funds of the association, deposit such funds in a bank designated by the board of directors and pay such bills only as shall have been approved by the president.

(b) She shall report to the board of directors the financial standing of the association whenever requested to do so and make a full report to the association at each annual convention.

(c) She shall keep an itemized account of all receipts and

disbursements and give a written report at meetings of the board of directors and of the association.

(d) She shall give a bond subject to the approval of the board of directors, and submit all books of account for audit as specified by the board of directors.

(e) She shall pay dues to the American Nurses' Association and send notice to district associations as specified in Article IV, Dues, of these bylaws.

The treasurer shall be a member of the Committee on Finance.

The retiring treasurer shall deliver to her successor within one (1) month after her election to office all money, vouchers, books and papers of the association in her custody with a supplementary report covering all transactions from the date of last audit to the date of surrendering her accounts to her successor.

The executive secretary shall assume such duties in connection with the work of the treasurer as shall be designated by the board of directors.

After the board approves attendance at any meeting called by the American Nurses' Association and for which that association will pay travel expenses but for which this association must pay living expenses, the treasurer may advance payment for plane fare and living expenses at the rate of $15 per day.

Section 6. All officers except the secretary and treasurer upon expiration of their term of office shall surrender all property of this association in their possession pertaining to their respective offices to the newly elected president.

Section 7. In addition to the duties of the officers set forth herein, the officers shall have such other duties as implied by their titles.

ARTICLE VII—Elections

Section 1. The president, the second vice-president and the treasurer shall be elected at the annual conventions held in the even years; and the first vice-president and the secretary shall be elected at the annual conventions held in the odd years.

The term of office of these officers shall commence at the adjournment of the annual convention at which they are elected and shall continue for two (2) years or until their successors are elected.

Section 2. At each annual convention two (2) directors shall be elected to serve for three (3) years or until their successors are elected.

Section 3. At each annual convention four members of the Committee on Nominations shall be elected to serve for one year.

Section 4. At the annual conventions held in the odd years three delegates-at-large shall be elected to serve as representatives of this association to the ANA convention to be held in the next even year. One alternate for each delegate-at-large shall also be elected.

Section 5. All elections shall be by secret written ballot. A ticket of at least two (2) candidates for each office shall be prepared and presented to the convention assembled by the Committee on Nominations. No names shall be presented to the convention unless the nominee has agreed to serve if elected.

Section 6. A plurality vote of those present entitled to vote and voting shall constitute election. The three nominees for the delegates-at-large to ANA convention who receive the highest number of votes shall be declared elected.

The three nominees for delegate-at-large to ANA convention who receive the next highest number of votes shall be declared elected as alternates.

In case of a tie, the choice shall be decided by lot.

Section 7. On the first day of the annual convention the president shall appoint a special committee of tellers who shall act also as inspectors of the election. There will be one teller from each constituent nurses' association. No nominee or candidate for any office shall be appointed a member of this committee.

Section 8. The secretary of this association shall furnish the tellers at least two (2) hours before the opening of the polls a complete list of delegates and alternates of constituent nurses' associations entitled to vote. The teller in charge of the list of delegates shall check the names of those voting.

Section 9. The teller in charge of the ballot box shall place her official mark upon the back of each ballot. The voters shall then place the ballot in the ballot box.

Section 10. Polls shall be open for such periods of time as specified by the board of directors and noted in the program of the annual convention.

Section 11. Additional nominations may be made from the floor of the convention and voting shall not be limited to the nominees.

Section 12. The tellers committee will report the results of the election to the House of Delegates without stating the number of votes received by each candidate unless requested to do so by the House of Delegates.

Section 13. All ballots, credentials of the voting body, and other records of the election shall be preserved for one year after the election.

ARTICLE VIII—Meetings

Section 1. This association shall hold an annual meeting known as the Annual Convention of the Hawaii Nurses Association at such time and place as shall be determined by the board of directors.

Section 2. The order of business of each annual convention of this association shall be in accordance with the program adopted at the beginning of the convention and shall include:

a. Call to order
b. Invocation
c. Appointment of tellers
d. President's address
e. Roll call of delegates
f. Report of Program Committee
g. Reading of minutes
h. Reports of officers
i Reports of sections
j. Reports of district nurses' associations
k. Reports of standing committees
l. Reports of special committees
m. Old business
n. New business
o. Election of officers
p. Adjournment

Section 3. Special meetings of this association may be called by the board of directors and shall be called by the president upon written request of a majority of the district associations.

Section 4. Notice of all meetings of this association shall be sent to the president and the secretary of each district association and to all members of this association prior to the meeting in question. Notices of the annual convention shall be mailed at least one (1) month before the first day of the convention and notices of special meetings shall be mailed at least ten (10) days before the first day of the meeting.

Section 5. Members of the Hawaii Student Nurses' Association may attend meetings of the Hawaii Nurses Association.

Section 6. Meetings of the Hawaii Student Nurses' Association may be held in connection with annual conventions at such times as shall be designated in the program of the conventions.

ARTICLE IX—Representation

Section 1. The voting body at all conventions and special meetings of this association shall consist of the board of directors of this association and the credited delegates in attendance from the constituent associations.

Section 2. (a) Each constituent association shall be entitled to one delegate for every ten (10) active members of each established section and/or the various areas of nursing practice representative of the established sections of this association. Any district nurses' association with fewer than ten (10) members in all such sections or areas of nursing practice shall be entitled one delegate.

(b) Delegate representation shall be computed on the basis of membership in the district nurses' associations 60 days preceding an annual convention or special meeting of

his association as evidenced by dues paid to this association r postmarked by such time.

(c) All delegates and alternates shall be elected by secret allot.

Section 3. (a) Not less than five weeks preceding the nnual convention and 30 days preceding a special meeting, ne secretary of this association shall notify each constituent ssociation of the number of delegates to which it is entitled.

(b) The secretary of each district nurses' association shall end a list of all the accredited delegates and alternates from nat association to the secretary of the Hawaii Nurses Asociation at least 30 days before the opening day of a conention or special meeting of this association.

(c) If all the accredited delegates from a district nurses' ssociation are not in attendance at the convention or special neeting, alternates fill the vacancies. Alternates shall become elegates in the order of votes received in the election, beinning with the alternate who received the highest number f votes.

Section 4. All delegates shall present credentials at the me of registration. No delegate, officer or board member nall be permitted to cast more than one vote in any elecon or on any matter coming before the convention or pecial meeting.

ARTICLE X—Representation at National Meetings

Section 1. (a) The Hawaii Nurses Association is entitled representation at biennial conventions or special meetings f the American Nurses' Association on the basis of one elegate for every two hundred (200) members of each ate section or fractional part thereof, provided that the umber of members does not fall below the numerical riterion for the establishment of a section and that such secons are organized according to criteria established by the merican Nurses' Association.

Delegates shall be elected by secret ballot of the active nembers of the section. A section may elect members of other ctions as delegates in order to fill its quota.

(b) Delegates are to be computed on the number of mems of each section of this association in good standing in ne American Nurses' Association on December 31 of the ear preceding a biennial convention or special meeting as videnced by annual dues paid that association or postmarked y such time.

(c) Not later than August 1 of the year between biennial nventions, the American Nurses' Association shall notify ne president and executive or elected secretary of this asociation of the number of delegates to which the association entitled.

(d) The Committee on Nominations of each state section ntitled to elect delegates to a convention or special meeting f the American Nurses' Association shall prepare a ballot r the election of such delegates in the odd years. Names r alternates shall also be included on the ballot.

Each section of each district nurses' association shall be sked to submit to the Committee on Nominations of the rresponding state section a list of nominees for delegates nd alternates. Where district sections do not exist, the disict nurses' association shall submit list of nominees selected cording to state section membership.

Section 2. The Hawaii Nurses Association is entitled to ree delegates-at-large to biennial conventions or special eetings of the American Nurses' Association. These deleates and their alternates shall be elected by secret ballot of ne voting body of this association.

Section 3. If a special meeting of the nurses' association held in the month of January or February of an odd numered year, the basis for computing the number of delegates which this association shall be entitled shall be the number members of this association in good standing in the Amerin Nurses' Association on December 31 of the preceding d year as evidenced by annual dues paid to that association postmarked by such time.

Section 4. The representatives of this association at meetgs of the Advisory Council of the American Nurses' Assoation shall be two (2) active members of this association, ne (1) of whom shall be the president of this association her alternate.

ARTICLE XI—Board of Directors

Section 1. The members of the board of directors of this association shall be eleven (11) composed of: the president, first vice-president, second vice-president, secretary, and treasurer, and six (6) directors, four (4) of whom shall be selected, one each from the respective districts, to serve as the official representative of that district, in addition to these the chairmen of organized sections of the Hawaii Nurses Association shall be regular members of the board of directors.

Section 2. The regular meeting of the board of directors shall be held immediately preceding and immediately following each annual convention* at the place where the annual convention is held. The regular meetings of the board may also be held at such time and place as shall from time to time be determined by action of the board.

Section 3. Special meetings of the board of directors may be called by the president of this association upon seven (7) days' notice to each member of the board either personally or by mail or by telegraph and shall be called by the president in like manner or by like notice upon the written request of five (5) members of the board of directors. Special meetings shall be held at such time and such place as may be specified in the notice thereof.

Section 4. In the intervals between regular meetings of the board of directors, the president of the association may refer and submit by mail or telegraph to the members of the board of directors definite questions relating to the affairs of the association which, in the opinion of the president, require immediate action on the part of the board of directors. The result of such a referendum which requires a majority vote of the personnel of the board of directors shall control the action of the association, its board of directors, officers, sections.

Section 5. Officers of the Hawaii Student Nurses' Association shall be eligible to attend meetings of the board of directors of this association in rotation, one officer attending each meeting but without notice.

ARTICLE XII—Duties of the Board of Directors

Section 1. The board of directors shall:

(a) Transact the general business of the association in the interim between annual conventions.

(b) Establish major administrative policies governing the affairs of the association and devise and mature measures for the association's growth and development.

(c) Provide for the maintenance of state headquarters and for making such office the center of activities of the association, including such work of the officers and committees as may be deemed expedient; provide for the proper care of materials, equipment and funds of the association, for the payment of legitimate expenses and for the annual auditing of all books of account by our agent if agency agreement is in effect; otherwise audit shall be made by a certified public accounting firm.

(d) Determine officers and other persons to be bonded, fix the amount of bond for each and approve same.

(e) Report to the association assembled at each annual convention through the secretary of this association the business transacted by the board during the preceding year.

(f) Assume responsibility with regard to constituent district nurses' associations as specified in Article II of these bylaws.

(g) Appoint an executive secretary and other personnel, define their duties and fix their compensation.

(h) Appoint special committees as the need arises to make it possible to carry out special projects and to promote the interest of the association without delay. A special committee expires when its purpose is accomplished and a final report has been made.

(i) Appoint standing committees and all committees not otherwise provided for.

(j) Fill vacancies on the Committee on Nominations and on the board of directors, except those occurring in the office of the president, first vice-president (second vice-president) or chairmen of sections.

* Except where government regulations or conditions incident upon war may render this impossible.

(k) Decide on the registration fee, date and place of the annual convention; hold meetings of the board of directors as hereinbefore provided.

(l) Provide for the establishment and dissolution of sections in accordance with these bylaws.

(m) Ratify votes of the board of directors secured by referendum.

(n) Appoint the association's representatives on Board of Management of the Mabel Smyth Memorial Building Committee in the manner provided for by the agreement made on October 15, 1939 between the Hawaii Nurses Association, the Hawaii Medical Association and The Queen's Hospital.

(o) Recommend to the Governor of the State the names of persons suitable for appointments to the board for the Licensing of Nurses when vacancies on said board occur.

(p) Shall have the right and authority by unanimous vote to appeal to the membership of this association, when necessary, for supplemental finances to carry on the program of the association.

(q) Appoint an active member, in addition to the president, or her alternate, to represent this association at meetings of the Advisory Council of the American Nurses' Association.

(r) Have the power to employ legal counsel and such other paid personnel as may from time to time be needed at fees made known to the board of directors in advance of such employment.

(s) Appoint an advisor to the Hawaii Student Nurses' Association.

Section 2. No individual member of the board of directors shall pledge any property of this association for security either for a personal or an association loan nor will members contact any liabilities in the name of the association without first having in their possession written permission from the treasurer of this association as approved by the board of directors.

Section 3. There shall be an executive committee, of the board of directors composed of the president, the officers and board members located on the Island of Oahu, and one other island director to be selected in rotation. This committee shall have all the powers of the board of directors to transact business of an essential nature between board meetings. All transactions of this committee shall be verified at the next regularly scheduled meeting of the board of directors.

ARTICLE XIII—Standing Committees

Section 1. (a) Standing Committees, except the Committee on Nominations, may be composed of active and associate members of the association and shall assume such duties as are assigned by the board of directors and specified in these bylaws. Standing Committees shall report to the board of directors when requested to do so. Only active members shall be chairmen of Standing Committees and on all Standing Committees active members shall be in the majority.

(b) Members of the Hawaii Student Nurses' Association shall be eligible to attend committee meetings of this association.

Section 2. The absence of a member without good cause from three (3) meetings of a committee constitute a resignation, and the vacancy shall be filled as provided for in Article XII—Duties of the Board of Directors.

Section 3. The following Standing Committees, with exception of members of the Committee on Nominations who shall be elected as hereinbefore provided, shall be appointed at or immediately after each annual convention to serve until the next convention or until their respective successors are appointed.

1. Finance
2. Promotion of Program, Public Relations and Membership
3. Legislation
4. Bylaws
5. Nominations (elected)
6. Professional Nursing Practice
7. Economic and General Welfare
8. Historian
9. Margaret Jones Memorial Fund

Section 4. The Committee on Finance shall consist of at least five (5) members including the treasurer of this association who shall serve as chairman.

This committee shall:

(a) Prepare the annual budget.

(b) Advise as to expenditures of funds and report same to the board of directors at meetings of that body.

Section 5. The Committee on Promotion of Program, Public Relations and Membership shall consist of at least seven (7) members, and be representative of various areas of nursing. This committee shall:

(a) Devise ways and means of assisting district nurses' associations which will promote increased membership.

(b) Assist in the integration of all programs of this association through appropriate cooperative efforts and inform nurses about the activities of the professional nursing organizations so they will support the organizations, benefit by their services and participate intelligently in their programs.

(c) Promote better understanding of professional nursing by the public so it will make discriminating use of professional nursing service and insist on sound preparation for nursing.

(d) Plan the program for conventions and meetings of this association.

Section 6. The Committee on Legislation shall consist of at least five (5) members. The membership of this committee shall be representative of the various sections of this association and the geographic areas of the state. The committee shall:

1. Study the needs for legislative action.
2. Study proposed federal, state, and local legislation for its implications for nurses, nursing and health.
3. Develop a state legislative program with the approval of the board of directors.
4. Advise the board of directors on legislative matters.
5. Assume such duties as shall be assigned by the board of directors.

Section 7. The Committee on Bylaws shall consist of at least three (3) members, one from each constituent district. This committee shall:

(a) Suggest and receive all proposed amendments to the bylaws of this association. Upon approval of such amendments by the board of directors, it shall be responsible for securing an opinion from the ANA Committee on Constitution and Bylaws with regard to the same, and shall recommend proposed action thereon to the board of directors of this association. Such proposed amendments shall be submitted for action to the voting body at the annual convention of the association in accordance with the provisions for amendments of these bylaws.

(b) Review the constitution and/or bylaws of any district nurses' association wishing to become a constituent association of the Hawaii Nurses Association, the committee shall report its findings to the board of directors of this association, whose decision as to the acceptability of the district shall be final.

(c) Advise district nurses' associations concerning proposed amendments to their constitution and/or bylaws in order that these may be kept in harmony with the bylaws of this association and of the ANA.

(d) Review the rules of each section and advise sections regarding proposed amendments in these rules in order that they will not be in conflict with the bylaws of this association.

(e) Review the constitution and bylaws of other state associations seeking recognition on the part of the Hawaii Nurses Association and make recommendations regarding the same to the board of directors.

Section 8. Committee on Margaret Jones Memorial Fund shall consist of at least three (3) members. The vice-president shall be a member (ex-officio) of this committee. The chairman of this committee, as appointed by the president, should be a nurse who has previously served as a member of the committee. It shall be the functions of this committee to receive requests for loans or gifts and to act upon them in accordance with the policies established in the deed of trust. To recommend to the board of directors, when the need arises, that certain loans be written off the books as gifts. To meet with representatives of the Bishop Trust Company each year following the audit of the fund to evaluate the yearly performance of our investments.

Section 9. The Committee on Economic and General Welare shall consist of not less than seven (7) members, and e representative of all areas of nursing. This committee hall:

(a) Study the principles and policies of ANA economic ecurity program.

(b) Devise and review policies and procedure manuals or the conduct of the state economic security program.

(c) Formulate objectives and periodically evaluate the ate economic security program and make recommendations egarding the same to the board of directors.

(d) Prepare educational programs and materials regardng the economic security program.

(e) Review and make recommendation on state legislaon having an effect on the economic and general welfare f nurses.

Section 10. Committee on Nominations shall consist of our (4) active members representing each district and who hall be elected as provided for in Article VII, Section 3, of hese bylaws. The member receiving the highest number of otes in the election shall be the chairman. Not more than ne member of this committee is to be a member of any one istrict nurses' association. The committee shall perform hese duties:

(a) Ninety days prior to the annual convention the Comittee on Nominations shall send to the constituent associaons the names of the officers serving, indicating those whose rms of office will expire at the next annual convention and hose eligible for re-election, together with the names of embers of the Committee on Nominations. The Committee n Nominations shall request from every district nurses' ssociation a list of names of active members representative f the established sections of those associations or of the NA. Those members shall be qualified and willing to serve the offices for which their names are submitted.

(b) In the odd years the Committee on Nominations shall so request a list of names of active members qualified and illing to serve as delegates-at-large or as alternates for elegates-at-large to the ANA Convention to be held in the ext even year.

(c) All lists shall be submitted not later than 60 days prior o the annual meeting to the Committee on Nominations of his association and shall be signed by the president or secetary of the respective constituent associations. From these sts the Committee on Nominations shall prepare a ticket onsisting of at least two (2) nominees for each office to be lled. The ticket shall be representative, insofar as possible, f the established sections as stated in paragraph (1), and he various geographical areas of the state.

(d) If it is not possible for the Committee on Nominaons to prepare a ticket as required in the preceding paraaph, each district nurses' association shall be requested to ubmit additional names of active members for those offices or which additional names are needed.

(e) If the name of a member of the Committee on Nomiations is submitted as a suggested candidate for the ballot f this association with the permission of that member, said ember shall resign from the committee.

(f) The ticket shall be presented to the board of directors f this association and then mailed by the secretary of this sociation to each district nurses' association at least 30 days rior to the annual meeting.

(g) Additional nominations may be made from the floor the convention and voting shall not be limited to the ominees.

(h) No name shall be presented at a convention either by e Committee on Nominations or from the floor unless the ominee has consented to serve if elected. No nominee shall pear on the ballot if election could result in concurrent embership on a state section executive committee or on e board of directors of any other state nursing organization.

Section 11. Committee on Professional Nursing Practice all be composed of seven (7) members of the association presenting the committee on functions, standards, and ualifications for practice of the sections. This committee all:

(a) Foster understanding and acceptance of nursing as a ofessional practice.

(b) Work to bring about adherence to ethical, professional and legal standards of nursing practice.

(c) Coordinate those activities of the committee on functions, standards and qualifications for practice of the sections of the state association which are designed to implement professional standards.

(d) Receive and take appropriate action upon complaints and related problems in nursing practice from the profession and the public.

Section 12. The historian will be responsible for maintaining the scrapbooks and other materials of historical record pertaining to this association. The historian will be appointed annually by the president.

ARTICLE XIV—Sections

Section 1. (a) Sections may be established by a majority vote of the board of directors of this association.

(b) A section may be established for each of the following groups of professional nurses:

(1) Private duty nurses
(2) General duty nurses
(3) Public health nurses
(4) Nursing Service Administrators
(5) Educational administrators, consultants, and teachers
(6) Occupational Health nurses

(c) Members of a branch group in the state shall be eligible to apply for status as a section when they meet the following criteria:

(1) In the Hawaii Nurses Association with a membership of less than 1500, if they number at least thirty-five (35); and
(2) If the members of the branch group desiring status as a section have functioned as a conference group within one of the established sections for a year; and provided the number of members of the section does not fall below the numerical criterion for establishment of the section (35).
(3) If they have demonstrated group interest; and
(4) If they have developed a program; and
(5) If the needs of such a group cannot be met in any existing section or by continuation as a conference group.

Section 2. Functions of sections may include the following:

(a) Define the qualifications for membership which are consistent with the general membership requirements of the Hawaii Nurses Association.

(b) Make rules for its government, provided these shall in no way conflict with the bylaws of the Hawaii Nurses Association and shall be approved by the board of directors.

(c) Define the functions, standards, and qualifications for practice within the occupational field, these to be developed for each special field by the practitioners within it.

(d) Initiate studies or experiments for the improvement of practice within the field in relation to the overall purpose of the Hawaii Nurses Association.

(e) Study the general welfare and economic needs of the members and develop desirable standards of employment.

(f) Promote the organization of subunits within the section in order that groups which have like interests shall have the opportunity of meeting to consider the economic security program separately from other groups in the same section whose economic interests might be somewhat different. The subunits shall have the privilege of reporting directly to the board of directors of the Hawaii Nurses Association.

(g) Represent the occupational interests in district, state, and national meetings.

(h) Develop relationships with allied professional groups for conferences or committee work related to the objectives of the Hawaii Nurses Association.

(i) Conduct programs of special interest to the members of the occupational group or participate with other sections that have similar interests.

(j) Organize conference groups on request for special interests within the section.

(k) Develop and actively promote a program for intergroup relations within the section.

(l) Plan a program of work and prepare an appropriate budget annually for presentation to the Hawaii Nurses Association Finance Committee.

(m) Make pronouncements in its own name, provided they are not in opposition to the policies accepted by the House of Delegates and do not purport to represent the policies of the association as a whole.

(n) Interpret all policies accepted by the House of Delegates that affect the section and publish same in its own name.

(o) Keep open direct channels of communication between the Hawaii Nurses Association and district sections with information going simultaneously to the executive secretary of the Hawaii Nurses Association and the presidents and the secretaries of the district nurses' associations.

Section 3. Officers of the section shall be chairman, vice chairman and a secretary. The officers shall be elected annually prior to the annual convention of this association. The newly elected secretary will forward immediately to the secretary of this association the names and addresses of all newly elected officers.

Section 4. A section may be dissolved by two-thirds vote of the board of directors upon the following conditions:

Upon the recommendation of the section concerned, or upon agreement by the board of directors and the section that there is no reason for its continuance, or upon the section's failure to carry out its objective or to conform with the requirements or principles of this association.

Section 5. A section which has been dissolved by action of the board of directors of this association in which the section does not concur, may appeal to said board of directors for reconsideration, or may appeal to this association shall be final.

Section 6. All members of a section in attendance at a section meeting are entitled to vote on all matters coming at any annual convention. The decision of this association before the section.

Section 7. Sections may engage in fund-raising, provided however, that plans for fund-raising be submitted to and approved by the board of directors.

ARTICLE XV—Duties of Constituent Associations

Section 1. It shall be the duty of each constituent district nurses' association of the Hawaii Nurses Association.

(a) To require that all of its members have the qualifications enumerated in Article III, Section 1, of these bylaws.

(b) To send to the secretary of this association the names and addresses of all officers of the district nurses' association immediately following their election or appointment.

(c) To confer with the Committee on Bylaws of this association before adopting any proposed amendments to its constitution and bylaws.

(d) To send to the secretary of this association a copy of the constitution and bylaws and all amendments adopted by the district nurses' association.

(e) To pay dues to this association as provided in Article IV, Sections 1 and 2, of these bylaws. Such dues shall be sent to the treasurer of this association with typewritten classified lists in duplicate of the members for whom dues are paid.

(f) To send to the secretary of this association the names and addresses of all those who are entitled to attend the annual convention as members of the voting body at least thirty (30) days before the opening day of the convention and to inform the secretary of all changes as promptly as possible.

(g) To nominate delegates to the biennial convention and special meetings of the American Nurses' Association in conformity with Article X of these bylaws and to send the names of those nominees, with addresses, to the secretary of this association.

(h) To report to this association as may be required by the board of directors in order to comply with the constitution and bylaws of the Hawaii Nurses Association.

ARTICLE XVI—Coordinating Council

Section 1. **Membership.** There shall be a Coordinating Council which shall be composed of all the officers and other members of the board of directors of Hawaii Nurses Association and all of the officers and other members of the boar of directors of the Hawaii League for Nursing.

Section 2. **Officers.** Starting with the president of th Hawaii Nurses Association, the president of that associatio and the president of the Hawaii League for Nursing shal serve alternately for one (1) year as chairman of the Coordi nating Council.

Section 3. **Purpose and Functions.** The coordinatin Council shall promote the coordination of those program that are of common concern to the Hawaii League for Nurs ing and the Hawaii Nurses Association. To promote suc coordination, the Coordinating Council shall:

(a) Serve as a forum for the discussion of different point of view for the purpose of reaching agreement when feasible

(b) Plan together, serve as a clearing house for activitie of common concern to both the Hawaii League for Nursin and the Hawaii Nurses Association and agree on allocatio of new major programs; and

(c) Consider priorities for and timing of interrelated ac tivities of the Hawaii League for Nursing and the Hawai Nurses Association.

The Coordinating Council shall also act as sponsors of an advisers to the state student nurses' council or organization

Section 4. **Steering Committee.** There shall be a Steer ing Committee for the Coordinating Council which shall b authorized to make recommendations when, because of a emergency or other special situation, a recommendation mus be made before the Coordinating Council can meet. Th Steering Committee for the Coordinating Council shall b composed of the president and elected secretary of the Hawai Nurses Association and the president and elected secretar of the Hawaii League for Nursing.

Section 5. **Special Committees.** The Coordinating Coun cil of the Hawaii Nurses Association and the Hawaii Leagu for Nursing shall have authority to appoint special com mittees if necessary.

ARTICLE XVII—Quorum

Section 1. Seven (7) members of the board of director one (1) of whom shall be the president or a vice-president and representatives from a majority of the constituent distric nurses' associations, shall constitute a quorum for the trans action of business at any annual convention or special meet ing of the Hawaii Nurses Association.

Section 2. Seven (7) members of the board of director one (1) of whom shall be the president or a vice-president shall constitute a quorum at any meeting of the board o directors.

Section 3. A majority of members of the Advisory Cour cil shall constitute a quorum of the Council.

Section 4. A majority of members of any standing o special committee shall constitute a quorum.

ARTICLE XVIII—Fiscal Year

The fiscal year for this association shall be the calenda year.

ARTICLE XIX—Parliamentary Authority

The rules contained in *Robert's Rules of Order Revise* shall govern all meetings of the board of directors, com mittees, special meetings and conventions of this associatio in all cases wherein they are applicable and not inconsister with these bylaws.

ARTICLE XX—Official Organs

The American Journal of Nursing and the Inter-Islan Nurses' Bulletin shall be the official organs of this associatio

ARTICLE XXI—Amendments

Section 1. These bylaws may be amended at any annua convention of this association by two-thirds vote of the a credited delegates present and voting. All proposed amen ments shall be in possession of the secretary of this associatio at least thirty (30) days before the date of the annual con vention and shall be appended to the call for the meetin

Section 2. These bylaws may be amended at any annua convention by unanimous vote without previous notice.

IN EMOTIONALLY PROJECTED
SMOOTH-MUSCLE SPASM...

Prompt, Profound

Protection...at both

ends of the vagus

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Professional reliance on the therapeutic proficiency of Pro-Banthīne in functional gastrointestinal disorders has made it the most widely prescribed anticholinergic.

The consistent relief of emotional tensions afforded by Dartal makes this well-tolerated tranquilizer a rational choice to support the antispasmodic action of Pro-Banthīne in emotionally influenced smooth-muscle spasm.

These two reliable agents combined as Pro-Banthīne with Dartal consistently control both disturbed mood and disordered motility when emotional disturbances project themselves through the vagus to provoke such gastrointestinal dysfunctions as gastritis, pylorospasm, peptic ulcer, spastic colon or biliary dyskinesia.

USUAL ADULT DOSAGE:
One tablet three times a day.

SUPPLIED as aqua-colored, compression-coated tablets containing 15 mg. of Pro-Banthīne (brand of propantheline bromide) and 5 mg. of Dartal (brand of thiopropazate dihydrochloride).



G. D. SEARLE & CO.
Chicago 80, Illinois
Research in the Service of Medicine

AMA DELEGATE'S REPORT

(Continued from page 264)

plan, as well as political activities of the Woman's Auxiliary and the Council on Legislative Activities.

Referred to the Judicial Council a request to clarify relationships with osteopaths in hospitals.

Endorsed and ordered published opinions of the Judicial Council with regard to excessive fees and proration of insurance benefits.

Anticipated hopefully a report of the Medical Disciplinary Committee due in June 1961.

Approved in detail a report of the Board of Trustees (JAMA 174:998-1005 (Oct. 22) 1960).

Asked the Law Department to prepare and issue a brochure on income tax returns.

Asked component societies to forward names and brief biographies of members willing to serve on councils and committees.

Advised component and constituent societies to form health insurance information or liaison committees to work with all legally constituted insurance or prepayment plans.

Ordered a resurvey of physicians' attitudes toward health insurance.

Agreed with the Committee on Medical Facilities that the trend toward location of doctors' offices in or near hospitals posed no immediate threat, but should be watched.

Urged as "required reading" the Committee's report on nursing home care.

Approved home care programs and their promotion.

Referred to state societies many suggestions by the Committee on Federal Medical Services (JAMA 174:1090-1096) to improve veterans medical care.

Debated lengthily a plea by the Committee on Medical Care for Industrial Workers that they could not establish Guides acceptable to closed panel people unless "free choice" were modified, and adopted a Colorado substitute motion directing them to try to do it anyway.

Endorsed statements by the Council on Medical Service regarding Aging, Public Assistance Medical Care, and Drug Expenditures for Welfare Patients.

Approved workshop conferences for 1961 for representatives of all areas in which relative value studies or plans are in effect.

Referred to the Trustees the question of advising against insurance for blood replacement costs, also a request that fees be set for surgical assistants.

Sidestepped a suggested recommendation that community health programs be administered by health departments.

Commended the Colorado Medical Society on an excellent program for health care for the aged.

Urged constituent associations to have professional service fees transferred from Blue Cross to Blue Shield.

Encouraged the Trustees to maintain interest in the marketing of drugs.

Accepted a recommendation that a blood alcohol level of 0.10% (instead of 0.15%) be accepted as evidence of intoxication.

Urged the promotion of Salk vaccine and asked the Trustees to have oral polio vaccine investigated promptly and a report sent out.

Referred the narcotic addition problem to the Council on Mental Health for further study.

Avoided a suggested stand on the harmful effects of tobacco.

Commended published brochures on relationships with voluntary health agencies.

Agreed there was no present need for a pension fund for needy physicians.

Declined to re-name the General Practitioner of the Year award.

Urged that all AMA members be told they will be welcome at Reference Committee meetings.

There was again some talk, as at Seattle three years ago, of the inordinate cost of these regional "Clinical" or "Interim" sessions of the Association. The substitution of meetings in Chicago "on call" was suggested. No decision was reached.

HARRY L. ARNOLD, JR., M.D.
A.M.A. Delegate

COUNCIL MEETING

(Continued from page 264)

ACTION:

It was moved and seconded that Dr. Harry L. Arnold, Jr., be confirmed as the HMA representative on the Advisory Board to the Institute of Health Research. The motion passed unanimously.

INCREASED TRAVEL EXPENSES FOR THE PRESIDENT

The members of the Council felt that there would be a greater need for inter-island travel by future HMA Presidents. Dr. Nishigaya thought this matter should be left to the discretion of each president. Dr. Burden said that during his term of office he would come over as often as necessary. Dr. Hartwell thought a definite sum should be set aside for the president to use. Some members thought the money could come out of the president's contingency fund and if more money is needed, more can be appropriated by the Council. Dr. Nishigaya thought the Council should not tie his hands and the other members concurred. Dr. Burden asked that he be given a little consideration on the time of the meetings.

ACTION:

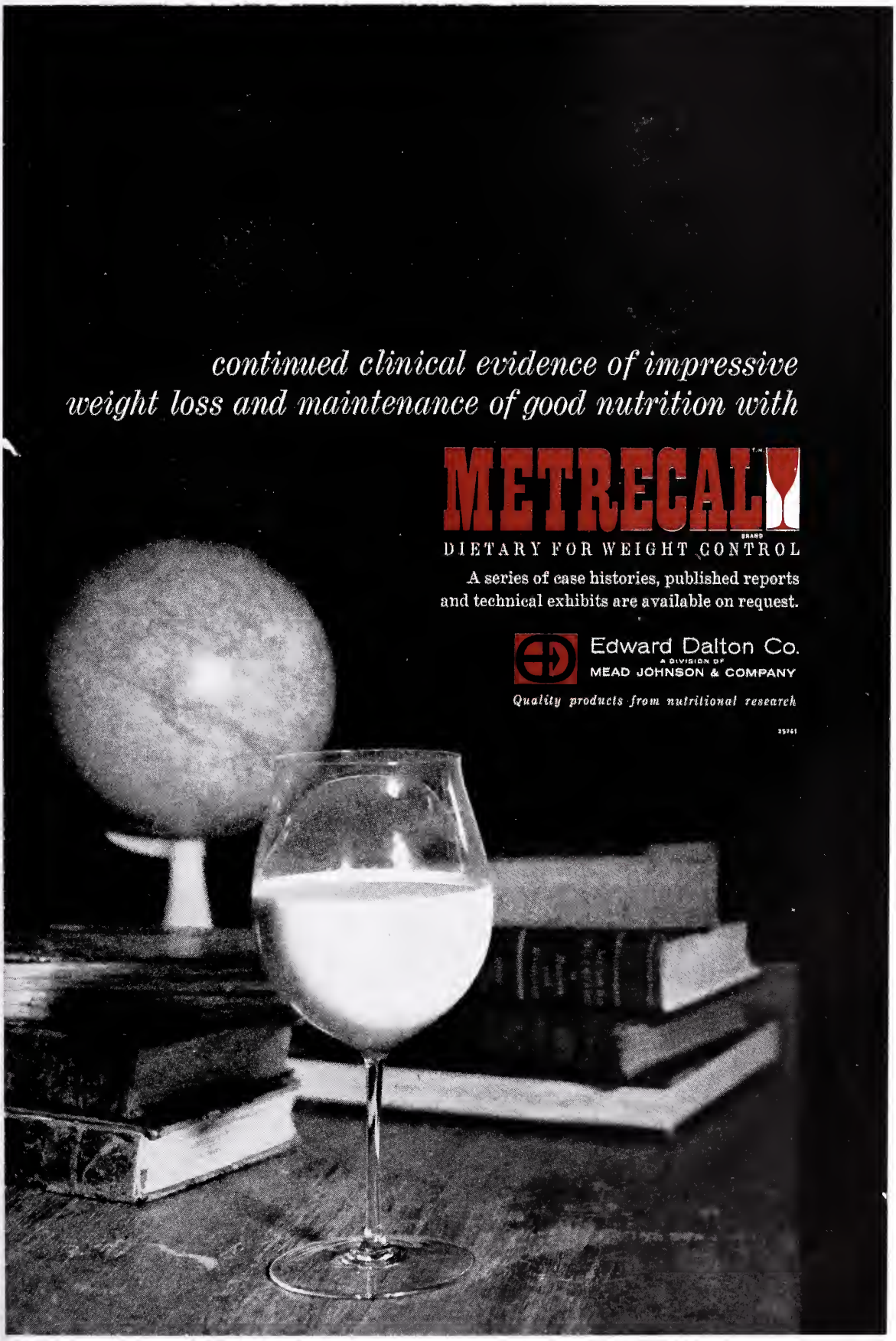
It was moved and seconded that Dr. Burden be given the right to send in all his expenses to the Association for trips as needed. The motion passed unanimously.

PUBLIC RELATIONS COUNSEL

Dr. Cushnie brought the Council up to date on what had taken place since the last meeting with reference to employing a public relations man. The Council was advised at its August meeting that the HCMS Board of Governors had accepted their fact finding committee's report to contract with Mr. Hugh Lytle to make an exhaustive thirty-day study for which he would be paid $1,000. The Board of Governors recommended that this be carried out at a state level. This study was made and Mr. Lytle's report was circulated to all the Council members. In accordance with the motion passed at the last meeting, a recommendation in writing was made to the Bureau of Medical Economics to employ Mr. Lytle to make the suggested study. We were advised that the Bureau would not be able to accept the financial responsibility for the survey and Mr. Lytle was paid out of the HMA treasury. After the survey was completed, two meetings were held with the members of Board of Governors, the HMA officers, and members of the fact finding committee.

Dr. Stevens was asked to summarize the findings of his committee. The fact finding committee made an exhaustive study of the problem and the possible solutions and it was their conclusion that Mr. Lytle should be employed on a part-time basis at $5,000.00 for the first

(Continued on page 286)


continued clinical evidence of impressive
weight loss and maintenance of good nutrition with
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DIETARY FOR WEIGHT CONTROL
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and technical exhibits are available on request.
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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

CAROLYN E. MCCUE, *Editor* BERYL UYEHARA, *Associate Editor*

*New Method for Blood Sugar Determination**

Standard blood sugar analysis has, in the past, been based on the reduction of ferricyanide or cupric ions in alkaline solutions. The specificity of these methods is not great, since many substances other than glucose can reduce these reagents. Modifications have been introduced to remove interfering substances by precipitation before analysis (Somogyi zinc sulfate method) which to some extent alleviate this difficulty. For the first time, a chemical method has been introduced which determines glucose alone. I should like to present a short discussion on this Glucostat method and its advantages.

An enzyme, glucose oxidase, is the basis of the Glucostat method. It was first extracted from Aspergillus niger and Penicillium glaucum. A purer extract is now obtained from Penicillium notatum. The glucose oxidase catalyzes the oxidation of glucose to gluconic acid. Molecular oxygen is needed for this reaction and it becomes reduced to hydrogen peroxide.

$$\text{glucose} + \text{oxygen} \xrightarrow[\text{oxidase}]{\text{glucose}} \text{gluconic acid} + \text{hydrogen peroxide}$$

The hydrogen peroxide formed reacts with a chromogenic hydrogen donor, ortho-tolidine or dianisidine. In the presence of horseradish peroxidase this reaction produces a color in proportion to the amount of glucose present.

$$\text{hydrogen peroxide} + \text{O-tolidine} \xrightarrow[\text{peroxidase}]{\text{Horseradish}} \text{color}$$

The Glucostat method is outlined as follows:

1. Add 5 ml Glucostat reagent, containing the coupled enzyme system, to a test tube—one for each specimen to be tested.
2. Add 0.05 ml serum (separated from clot and used within two hours) to reagent—adding each serum at timed intervals.
3. Prepare a blank with 5 ml Glucostat reagent.
4. Prepare a standard with 5 ml Glucostat reagent and 0.05 ml Glucostat standard. Prepare another standard after every five unknown tubes.
5. Let all tubes incubate for the time specified for maximum color development.
6. At the end of the incubation time, stop the reaction by addition of two drops of 4N HCl, at the same timed intervals as the serums were added. Add the HCl to the blank and standard also.
7. Read optical density at 425 μ's, setting the machine to zero with the blank.
8. Calculation:

$$\frac{\text{Reading of unknown}}{\text{Reading of Standard}} \times \text{concentration of standard (100)}$$

Normal ranges are 70-105 milligrams per cent in plasma. Heparinized blood gives results that are 3-5 milligrams per cent lower. There is no significant loss of glucose while clotting proceeds for at least two hours. The use of sodium fluoride as a preservative prevents glycolysis for forty-eight hours without inhibiting the action of the enzyme. Refrigerating the serum at 6°C. results in no appreciable loss of glucose over an eight-hour period.

In order to get stoichiometric values, an incubation period of 20 to 60 minutes is needed. However, after five minutes the decrease in rate of color development is such that readings can be made without significant loss of accuracy. At the end of the incubation time, the enzyme reaction is stopped by addition of acid. This also acts to eliminate turbidity.

A pH of 7.0 is maintained in the reagent, which contains the coupled enzyme system, by a dilute phosphate buffer. This pH is necessary to give true values.

Results are lowered by the presence of all enzyme inhibitors in the protein fraction of the plasma. A stabilizer containing Versene is added to the Glucostat reagent to eliminate this factor. This avoids the necessity of preparing a protein-free filtrate, the test being performed directly on serum, as a result.

Ascorbic acid and uric acid interfere with the test results. The small amounts of uric acid normally present in the blood are negligible. In the urine where uric acid is present in a greater amount, the addition of charcoal removes it and prevents any resulting error.

Hemolyzed blood does not give true readings by this method. In these cases, a Somogyi-Nelson filtrate must be made, and the test run on the filtrate.

The merits of the Glucostat method are numerous.

Specificity is very high—other than glucose, only mannose and xylose are oxidized, and these are

* First published by the New Jersey Society of Med. Tec. Inc.

ot found in serum. Elimination of water-baths ıtroduces a great saving of time. Commonly used rugs have no adverse effects on results. The aver-ge error in the Glucostat method is about two er cent.

CHARLOTTE WINTASCH

ergen Pines Hospital School

*Jew Methylene Blue as a Reticulocyte Stain**

New methylene blue (Color Index 927) is hemically different from methylene blue (Color ndex 922) which is a poor reticulocyte stain.

. Preparation of stain

New methylene blue (Color Index 927)	0.5 gm.
Potassium oxalate	1.6 gm.
Distilled water	100.0 ml.

. Procedure

1. Approximately equal amounts of staining solution and fresh or oxalated blood are mixed on a slide.
2. The mixture is drawn up into a capillary pipette, allowed to stand for 10 minutes, expelled on a slide, and mixed again.
3. Thin smears are then made and air-dried.
4. Reticulocytes are counted under oil immersion without fixation or counterstaining. The red blood cells are light greenish blue and the reticulum is sharply outlined and deep blue.

. Discussion

Simplicity; no counterstaining because red cells re clearly visible. New methylene blue (color in-ex 927) is superior to brilliant cresyl blue as re-culocyte stain because of its uniform performance nd the sharp, deep blue staining of the reticulum hich facilitates identification and enumeration of eticulocytes.

Rheumatoid Arthritis Test

This test is rapid slide test for rheumatoid fac-or, which was developed by persons with rheu-natoid arthritis. The RA-Test is available as a it containing Latex-Globulin Reagent, Positive nd Negative Control Serums, Glycine-Saline uffer Diluent and a divided glass slide.

rocedure:

Prepare an approximately 1:20 dilution of the serum under test by adding 1 drop of serum to the 1 cc of Glycine-Saline Buffer Diluent.

Place 1 drop of diluted serum specimen in a rectangle of the divided slide.

Add 1 drop of Latex-Globulin Reagent, mix with an applicator stick.

Prepare positive and negative controls, each with 1 drop of appropriate RA-Test Control Serum and 1 drop Latex-Globulin Reagent. Use applicator stick to mix.

Tilt the slide from side to side for 1 minute and observe for macroscopic clumping.

6. Serums containing rheumatoid factor produce visible flocculation of RA-Test Reagent whereas a smooth suspension will be observed in a negative reaction. In positive tests, visible flocculation usually occurs in a few seconds.
7. Recommended method of reading the test is as follows:
   Negative—Smooth suspension with no visible flocculation, as shown by negative control.
   Weakly reactive—Visible flocculation, but with small aggregates or partial clumping.
   Reactive—Visible flocculation with large aggregates and complete clumping as shown by positive control.
8. The incidence of false positive screening test reaction with serum specimens from healthy individuals is about 4%. Most of these specimens are, however, only weakly reactive.

GEORGE BRECHER, M.D.

Prepared by the Hyland Laboratories.

Open Letter to Constituent Societies

Recently an application form for a new examination and registration of an applicant as a "Certified Technician" has been widely mailed to the laboratory personnel in hospitals. It should be made *clear* that this form was not prepared by or disseminated from the Registry of Medical Technologists of the American Society of Clinical Pathologists in Muncie, Indiana, or The American Society of Medical Technologists in Houston, Texas.

Similarity of form, titles, and wording may well be confusing to hospital administrators and even to medical technologists and pathologists, to say nothing of busy physicians who are not pathologists. Such confusion can be avoided if it is made clear that medical laboratory personnel use the letters (ASCP) if they are certified by the Board of Registry of Medical Technologists of the American Society of Clinical Pathologists.

You are urged to contact your medical technologists, pathologists, and hospital administrators so that they may be alerted to this new material. Point out that medical technologists certified by the Board of Registry in Muncie, Indiana, use M.T. (ASCP) after their names; that chemists so certified use C. (ASCP); cyto-technologists use C.T. (ASCP); microbiologists use M. (ASCP); blood bankers use B.B. (ASCP); and histologic technicians use H.T. (ASCP).

It is important that this contact be made now! Call attention to the fact that ASMT is a professional organization with ethical standards whose membership is composed of individuals holding certificates from the Registry of Medical Technologists of the American Society of Clinical Pathologists, and that this is the only Registry of Medical Technologists recognized by the American Medical Association.

ASMT EXECUTIVE OFFICE

* Am. Jl. of Clinical Path., vol. 19, 1949.

END BATTERY REPLACEMENTS



ACTUAL SIZE

NEWEST Welch Allyn RECHARGEABLE HANDLE

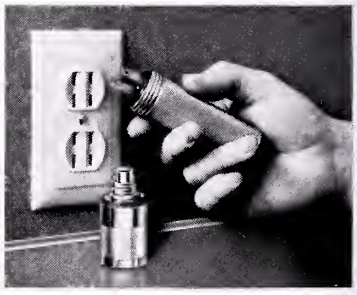
Fits all WA medium-handle set cases

- Provides satisfactory illumination longer between charges than standard medium batteries.
- No separate charger. • Cannot overcharge.
- May be recharged thousands of times.
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An ideal arrangement for many doctors is to have two bottom sections and one top, so that one bottom section can be charging while the other is in use.

No. 717 Rechargeable battery handle *$20.00*
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Also available as part of combination sets.



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you're treating coccal fection...

ou can't prescribe a more fective antibiotic than

ERYTHROCIN

Erythromycin, Abbott

w much "spectrum" do you need in treating an ction? Clearly, you want an antibiotic that will v the greatest activity against the offending or- ism, *and the least activity against non-patho- c gastro-intestinal flora.*

gh these criteria—and make this comparison— n treating your next coccal infection. Erythrocin medium-spectrum antibiotic, notably effective against gram-positive organisms. In this it comes close to being a "specific" for coccal infections—*which means it is delivering a high degree of activity against the majority of common infection-producing bacteria.*

And against many of the troublesome "staph" strains—a group which shows increasing resistance to penicillin and certain other antibiotics—Erythrocin continues to provide bactericidal activity. Yet, as potent as Erythrocin is, *it rarely has a disturbing effect on normal gastro-intestinal flora.* Comes in easy-to-swallow Filmtabs®, 100 and 250 mg. Usual adult dose is 250 mg. every six hours. Children, in proportion to age and weight. Won't you try Erythrocin?

®Filmtab—Film-sealed tablets, Abbott.

ABBOTT

COUNCIL MEETING

(Continued from page 280)

year. He should be on call at all times, attend important committee and society meetings, and spend some time in the executive offices. The modus operandi had been discussed at length but no final conclusions have been made. Dr. Stevens said he would circulate a plan to the members of the Council and asked that after they have an opportunity to review it, it be returned with comments and suggestions. It was noted that each county would be represented on the state committee and the public relations man would be made available to each county. The representatives from the neighbor islands were asked to comment on the proposal. They agreed that there was a need and felt that their societies would go along with the idea. They offered suggestions for implementing the program on the neighbor islands. One was that their local newspapers receive releases to coincide with their publication deadlines.

Dr. Allison spoke on the past activities of the Association. He said there was no question that we need such a program. About 1947 the membership was assessed a rather large sum for a public relations program. It was apparently quite effective in doing certain things but there was some opposition from some of the members and it was discontinued. There was money left over. Around 1950 or 1951 several firms were interviewed and a survey was made which is probably still valid. The HMA has a Health Education and a Public Relations Committee but they have never been supported. He told of Dr. Tell Nelson's radio program for which he had no support. At that time it was felt there was a need for a man who could help with this idea. He told how hard Dr. Edgar had worked on the television programs and how little help she had received. He said as he recalled the facts, when the Bureau of Medical Economics came into being, one of the things it was to do was to provide money for this program.

Dr. Hartwell said that they would like to give every nickel they could but they are in a tax bind since they can give only 5% away and the balance is taxable. The only way they can make this money available is to provide a service for their members. They are now considering two things: a printing press to replace the mimeograph equipment and payment for the doctors HAWAII MEDICAL JOURNALS. They will have to move twice in the next couple of years and they want to set aside money for this purpose. If they gave the money away and had to pay taxes on it, most of it would go to taxes. The original bylaws state nothing about public relations. The money must be returned to members according to the amount they have invested in it. He expressed the hope that everyone would attend the next Honolulu County Medical Society meeting when this will be discussed and if anyone can figure out how the BME can give the money, as far as he is concerned, every nickel of it could be given away.

A lengthy discussion followed on financial aspects of the proposed program and how much secretarial help would be needed to implement the program and reap the greatest benefits. Whether we should suggest a $15.00 assessment rather than a $10.00 assessment was discussed pro and con. Dr. Stevens was complimented on the good work his committee had done. It was agreed that after the program has been in operation it will be much easier to determine the total costs and this should be presented to the House of Delegates in May.

It was noted that Mr. Lytle will keep his offer open

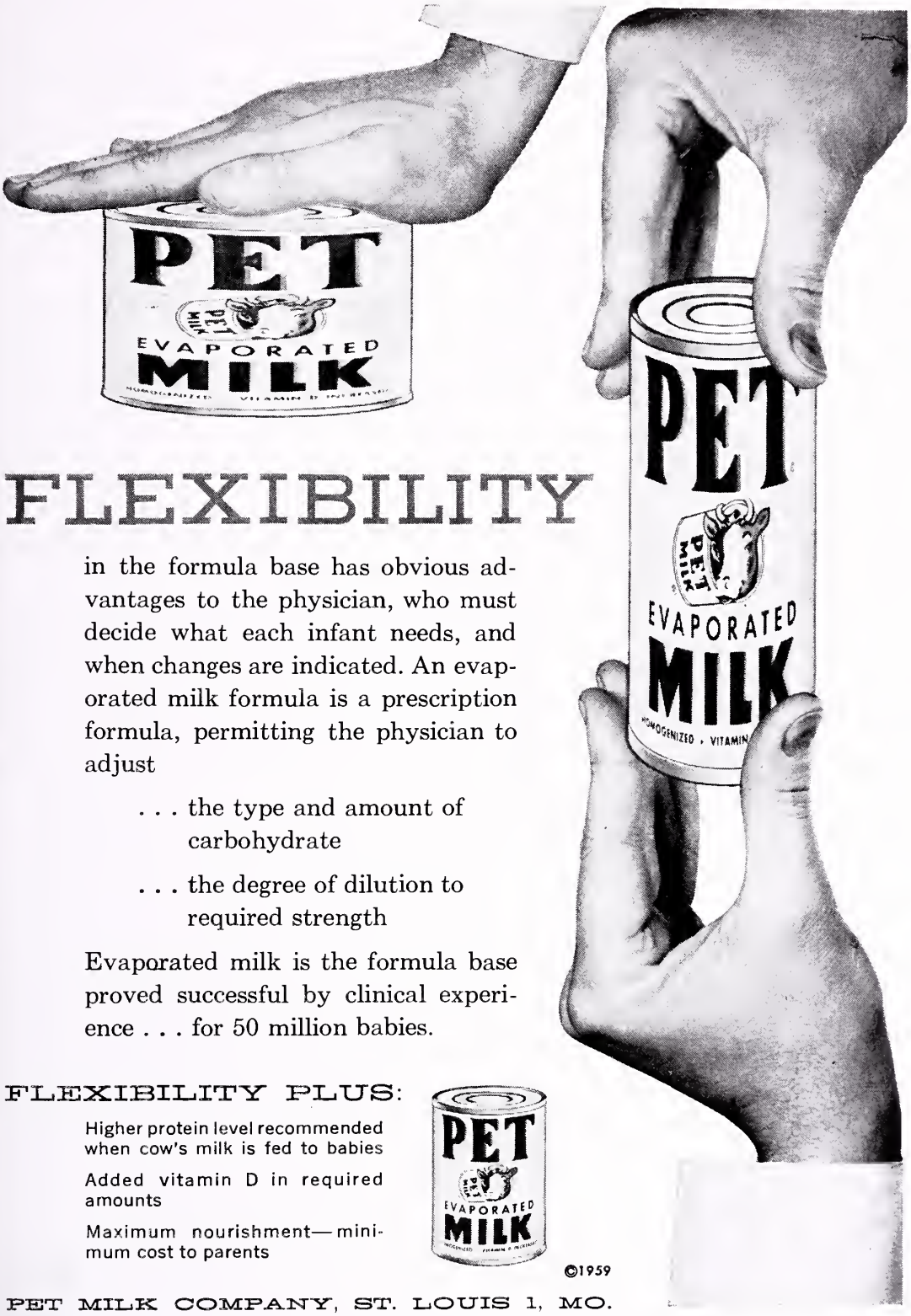
(Continued on page 290)



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FLEXIBILITY

in the formula base has obvious advantages to the physician, who must decide what each infant needs, and when changes are indicated. An evaporated milk formula is a prescription formula, permitting the physician to adjust

. . . the type and amount of carbohydrate

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Evaporated milk is the formula base proved successful by clinical experience . . . for 50 million babies.

FLEXIBILITY PLUS:

Higher protein level recommended when cow's milk is fed to babies

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as salt goes, so goes edema

A basic principle of diuresis is that "increased urine volume and loss of body weight are proportional to and the osmotic consequences of loss of ions."[1]

Robins' new NaClex is a potent, oral, non-mercurial diuretic that helps reduce edema through the application of this fundamental principle. It limits the reabsorption of sodium and chloride in the renal proximal tubules (*with a relative sparing of potassium*). The body's homeostatic mechanism responds by increasing the excretion of excess extracellular water. Thus the NaClex-induced removal of salt leads to a reduction of edema.

a unique chemical structure

NaClex (benzthiazide) is a new molecule which provides a "pronounced increase in diuretic potency"[2] over its antecedent sulfonamide compound. Compared tablet for tablet with current oral diuretics, it is unsurpassed in diuretic potency.

twofold value

NaClex produces diuresis, weight loss, and symptomatic improvement in edema associated with various conditions. It also has antihypertensive properties and may be used alone in mild hypertension or with other antihypertensive drugs in severer cases.

For complete dosage schedules, precautions, or other information about NaClex, please consult basic literature, package insert, or your local Robins representative, or write to the A. H. Robins Co., Inc.

Supply: Yellow, scored 50 mg. tablets.

References: 1. Pitts, R. F., Am. J. Med., 24:745, 1958. 2. Ford, R. V., Cur. Therap. Res., 2:51, 1960.

A. H. ROBINS COMPANY, INC.
RICHMOND 20, VIRGINIA

WINE...

Rx Now widely prescribed for the chronic invalid, the convalescent, the debilitated oldster

Physicians treating the aged and the convalescent have for generations been aware of the restorative power of wine. However, it remained for recent research* to more clearly define its clinical physiological action.

Wine Increases Appetite—Goetzl and co-workers[1] observed a profound stimulating effect on olfactory acuity and appetite, even in anorexia.

Wine Aids Gastric Digestion—Ogden and Southard[2] reported a significant increase in gastric secretion following ingestion of moderate amounts of table wine.

Wine Helps in Cardiology—Prudent quantities of wine are helpful[3] in counteracting depression, anxiety and discomfort in sufferers from heart and coronary disorders.

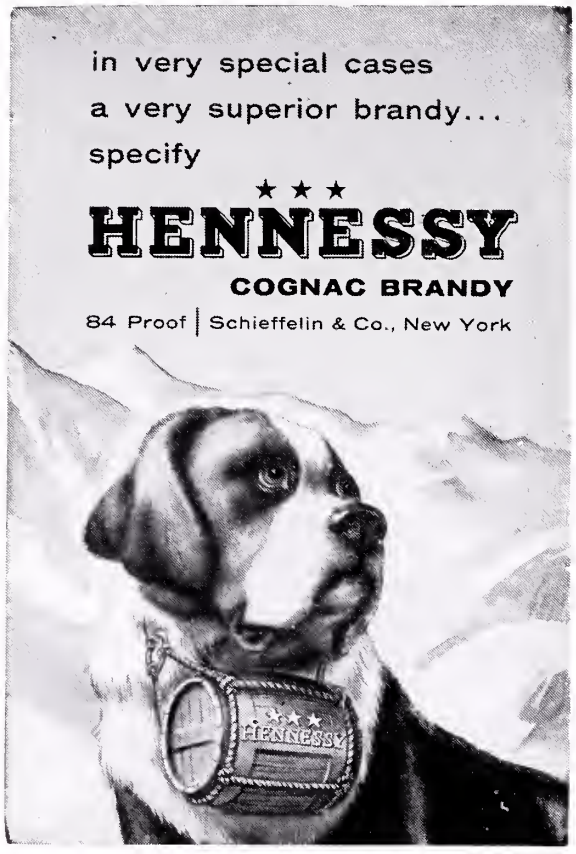
Wine—"safest of all sedatives..."[4]—A little Port or Sherry at bedtime offers a valuable relaxant to the insomniac and may obviate the need for drug-sedative medication.

In brief, wine taken with discretion adds greatly to the pleasures of the table, to physical comfort and to mental serenity in the aged, as well as in the chronic sufferer and the convalescent.

Research information on wine is available on request. Write for your copy of *"Uses of Wine in Medical Practice." Wine Advisory Board, 717 Market Street, San Francisco 3, California.

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1. Goetzl, F.R.: Permanente Found. M.Bull. 8:72 (April) 1950.
2. Ogden, E., and Southard, F.D., Jr.: Fed. Proceedings 5:77 (1946)
3. Brooks, H.: Med. J. & Rec. 127:199 (1928)
4. Haggard, H.W., and Jellinek, E.M.: Alcohol Explored, New York, Doubleday, Doran, 1942.



COUNCIL MEETING

(Continued from page 286)

until the first of the year and action has to be taken righ away. The neighbor islands will contribute little of th money but in principle the work should be state-wid and the public relations man will cooperate with all th doctors. Dr. Burden noted that on Maui they get abou 90% attendance at their meetings and so they get pretty honest expression at their meetings. He though they would go for $10.00 but questioned if they woul go for $15.00. Looking at the attendance figures at th Honolulu meetings, he wondered if the Society as whole would accept what is passed by a minority of it members. Dr. Hartwell thought it was a matter of edu cating the membership. The next meeting will be hel on the second Tuesday in January and except for th BME report, this will be the only thing on the agend He said he was convinced that we would have to hav enough money if we are going to do it right. Dr. Steven said that the $10.00 figure was a bare minimum an if we can get $15.00, so much the better. It was though that perhaps a $5.00 assessment could carry us throug until May when the House of Delegates could make a additional assessment if needed. Dr. Izumi thought pe haps if someone came down to Maui and sold the ide they probably would get $15.00. Dr. Goodhue felt tha his Society would go for $15.00. Dr. Hartwell was aske if he thought he could swing his Society on a $15.0 assessment and he said he thought he could.

ACTION:

It was moved and seconded that we present the public relations program to each of the county so-

(Continued on page 294)

Pharmaceuticals Needed Urgently?

Call Rex McKay Service

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McKESSON & ROBBINS INC.

Hawaii's only full line service drugs wholesaler

Complete library of product information

Automatic shipment of new products

Special Orders ***No Extra Charge***

Just had one of the
best deliveries of my career....
a "Baby-Blue"

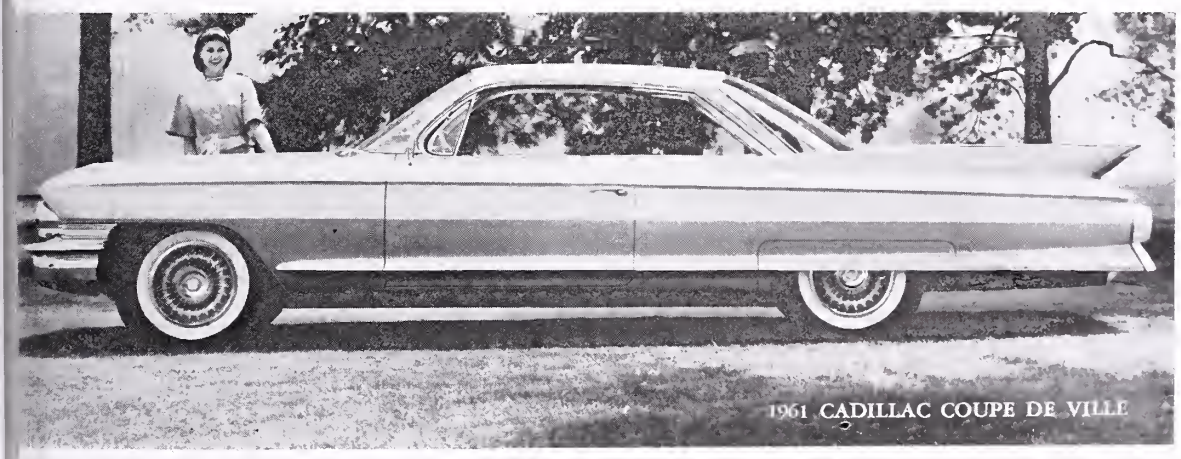


Cadillac

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Source: Harrison, T. R., *et al.*: Principles of Internal Medicine, ed. 3, New York, McGraw-Hill Book Co., 1958, p. 620.

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COUNCIL MEETING

(Continued from page 290)

cieties and stress to them the needs and importance of this work and ask each county society to assess its members $15.00 each to cover the expenses for the ensuing year. The motion passed unanimously.

It was moved and seconded that we go on record as preferring Mr. Hugh Lytle to take over the work as public relations man on the basis outlined in Dr. Stevens' report. The motion passed unanimously.

PERSONNEL COMMITTEE REPORT

It was noted that there was an error in the report as circulated; the sixth and seventh lines of the third paragraph should read "After five years of continuous employment the full-time employee will become eligible for 15 working days of vacation.

ACTION:

It was moved and seconded that the recommendations of the personnel committee's report dated November 25, 1960, be approved as circulated. The motion passed unanimously.

POLITICAL ACTION COMMITTEE

Dr. Cushnie asked the neighbor island representatives how the new political league was being accepted on their islands. The members present were not aware of any activity on this and it was agreed that Dr. Ando should be advised of this.

NOMINEE FOR POSTGRADUATE MEDICINE'S BIOGRAPHICAL SKETCH

Dr. Cushnie advised that a committee consisting of Drs. Harry L. Arnold, Jr., F. J. Pinkerton, and Nils P. Larsen felt that Dr. William Hillebrand should receive this honor.

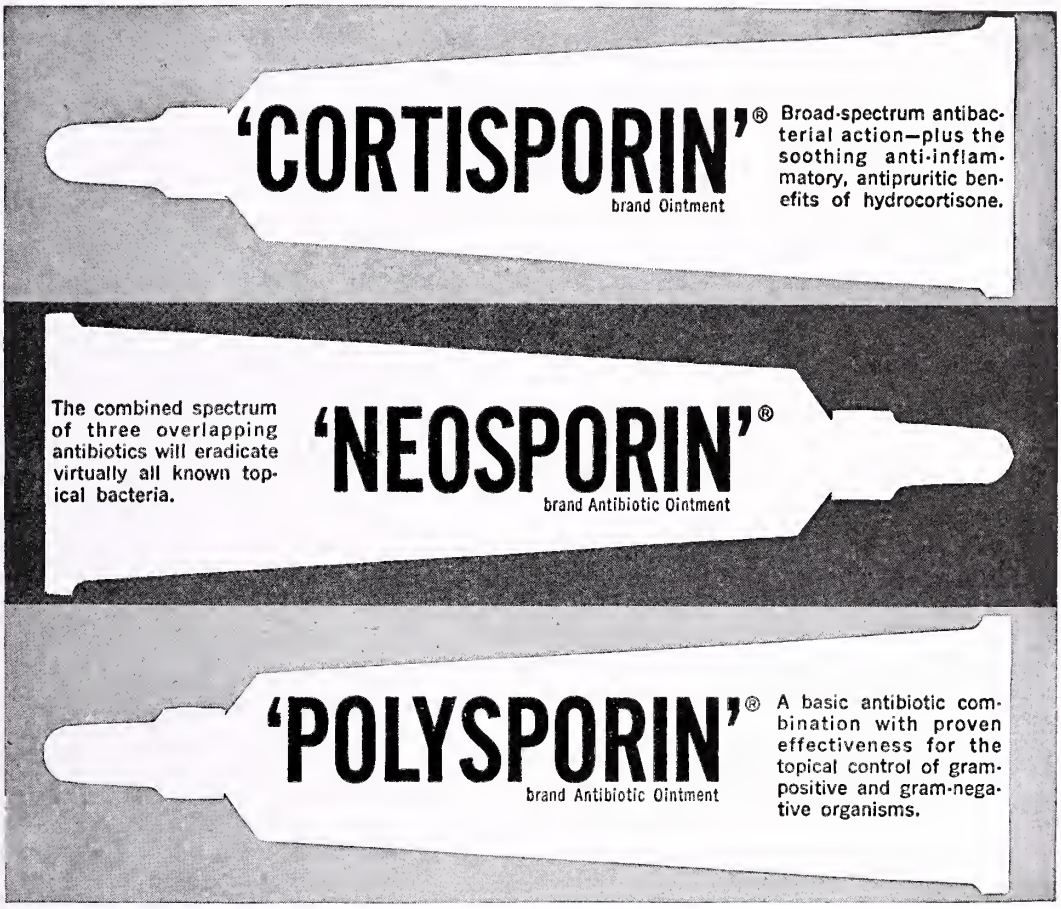
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OUNTY SOCIETY REPORTS

(Continued from page 268)

ave a brief introductory talk on the workings of the Medical Payments Program for Indigent and Medically ndigent.

In accordance with the request of Miss Lee McCaslin, he President appointed Dr. Andrews and Dr. Fleming s nominees, one of whom will be appointed by Miss Joonan as Maui County representative to the Medal Advisory Committee to the Department of Social ervices.

A letter from Mrs. Elizabeth Fleming, secretary of the Woman's Auxiliary, was read regarding the placement f the Volumes of "In Memoriam, Doctors of Hawaii" a safe yet accessible place. This matter was acted upon veral years ago, however, it was again moved by Dr. conetti and seconded by Dr. Andrews and passed nanimously that the volumes be placed in the County ibrary. A letter to that effect has been written to Mrs. eming.

Dr. Tompkins announced that the Tuberculosis Asciation intended to skin test all high school sophomores nd he requested that the Maui County Medical Society ve their approval. It was so moved by Dr. Iaconetti, conded by Dr. Kliewer and unanimously passed.

Dr. Kliewer brought up the subject of unethical adertisement on the part of Dr. C. V. Caver of Honolulu. r. Sanders moved and Dr. Fleming seconded that a tter be directed to Hawaii Medical Association expressg the views of our Society and that such "unethical dvertising" be condemned. Passed unanimously.

S. OHATA, M.D.
Secretary

Honolulu

The Honolulu County Medical Society met on Tuesay, October 11, 1960, in the Mabel Smyth Auditorium 7:30 P.M. Approximately 75 persons were present.

A panel discussion on "Hospital Costs" was held. Disssants were: Dr. Sumner Price, Administrator, Queen's ospital; Mr. Albert Yuen, Operations Manager, HMSA; r. O. D. Pinkerton, Secretary, HCMS; and Mr. Will enderson, Administrator, Children's Hospital; with Mr. ichard M. Kennedy, Moderator.

A question and answer period followed.

The following new members were acknowledged: Dr. ydia K. Bolosan, Dr. Kenneth Chinn, Dr. Albert K. S. hun, Dr. Edward Furukawa, Dr. Jack K. Ikeda, Dr. elix J. Lafferty, Dr. Carl H. Lum, Dr. James L. Mertz, r. Reynold S. Shirai, and Dr. Arthur K. Wong.

Dr. Hartwell, chairman *pro tem*, announced that Dr. iyoshi Inouye had been presented with an Award of Merit by the American Medical Education Foundation or 1959-60, in recognition of his generous aid to medical ducation.

A resolution in memory of Dr. Erwin Cheim was read y Dr. O. D. Pinkerton and was adopted by a unanimous ote of the membership. The resolution read as follows:

Erwin Cheim was born in Bonn, Germany, on November 9, 1900 and died on September 17, 1960.

He had been an associate member of the Honolulu County Medical Society since December 27, 1949. He was a graduate of Christian Albrecht University Medical Faculty in Kiel, Germany. Dr. Cheim came to the United States, was licensed in the State of New York in 1935 and was a member of the Kings County Medical Society. Dr. Cheim ably served this country as a physician and surgeon in the United States Army and was a veteran of World War II. After the war he was retired as a Major from the U. S. Medical Corps and came to Hawaii where he assumed the position of director of the Veterans Administration Out-Patient Clinic.

He is survived by his widow Emilie M. Cheim and a brother and two sisters.

WHEREAS, Dr. Erwin Cheim was an associate member of the Honolulu County Medical Society and a retired medical officer of the U. S. Army,

WHEREAS, for the past ten years he has run the Out-Patient Clinic of the Veterans Administration in Honolulu with kindliness and efficiency,

BE IT RESOLVED, that the Honolulu County Medical Society mourns the passing of this fine member of the medical profession and that this resolution be spread upon the minutes of the Society and that a copy be sent to his widow.

An informal discussion was held on the advantages of forming a political action group composed of doctors, independent of the Honolulu County Medical Society. Dr. Fernandez, chairman of the Legislative Committee, gave several reasons why such a political action committee would be advantageous to the doctors not only from the standpoint of being a political force but mainly because they would be able to help financially. He stated that where the present Legislative Committee cannot do a lot of things, through this Political Action Committee, more positive action can be done. Dr. Cushnie stated that he felt that this Political Action Group should be formed on a state level inasmuch as the work of such a group would affect doctors and legislators from the other islands as well. He stated that the HMA has started the ball rolling and have asked Dr. Ando and Dr. Hartwell to take the format and set up plans for such a group.

Following further discussion, it was moved by Dr. Hartwell that the Honolulu County Medical Society adjourn its meeting and that everyone present stay a few minutes longer to discuss further this matter of a Political Action Committee. The motion was seconded and was carried.

* * *

The Honolulu County Medical Society met on September 6, 1960, at 7:30 P.M., in the Mabel Smyth Auditorium. Approximately 135 persons were present.

A film by the Honolulu Community Chest was shown.

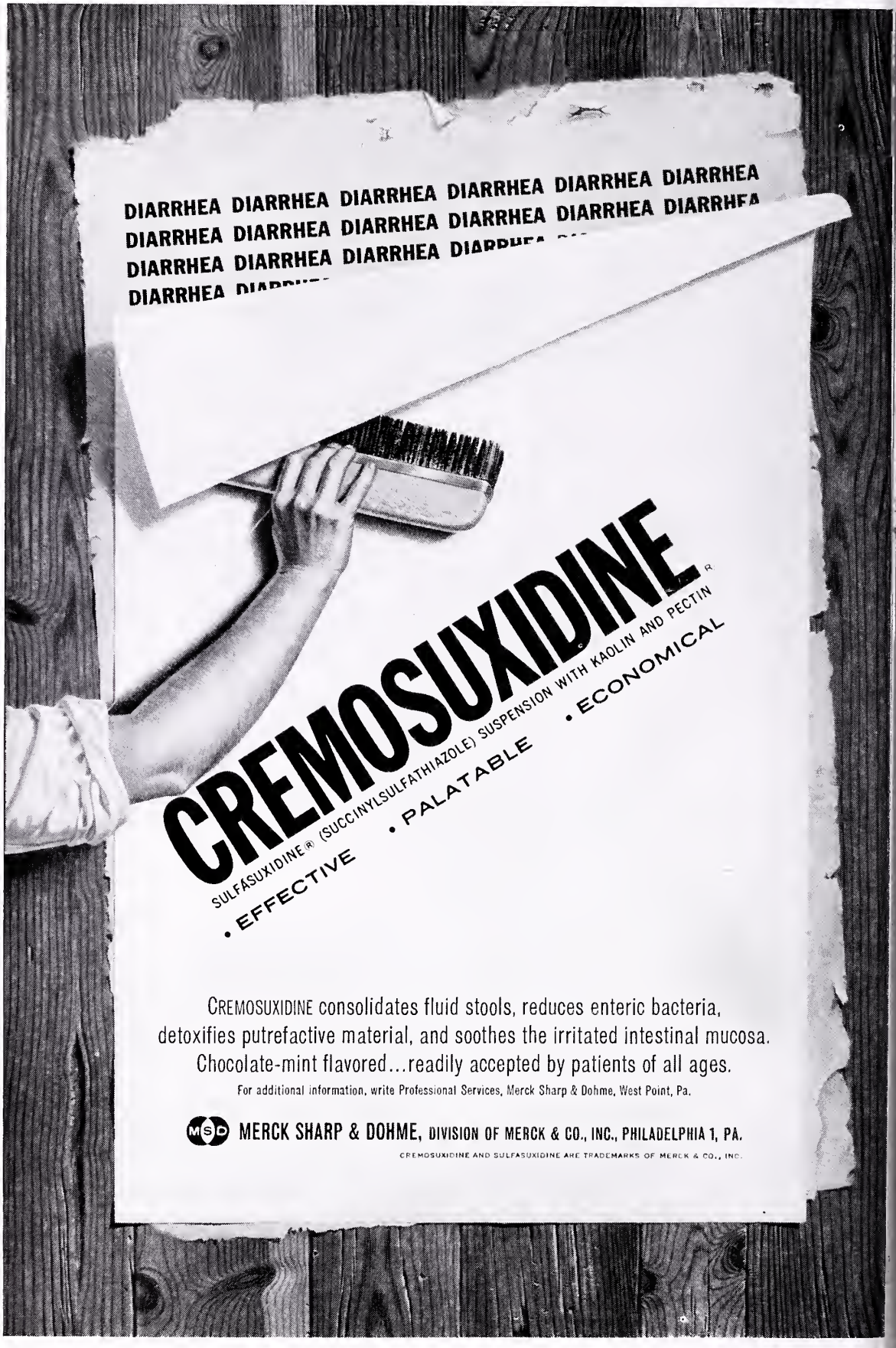
A joint meeting of the Hawaii Bar Association and the Honolulu County Medical Society was held to discuss "Problems of Medical-Legal Testimony." A panel of three doctors and three attorneys discussed "Referral of patients by attorneys." "Remuneration for medical-legal testimony" and "Doctor-patient relationship in court." A question and answer period followed the panel presentation. Moderator was Daniel H. Case.

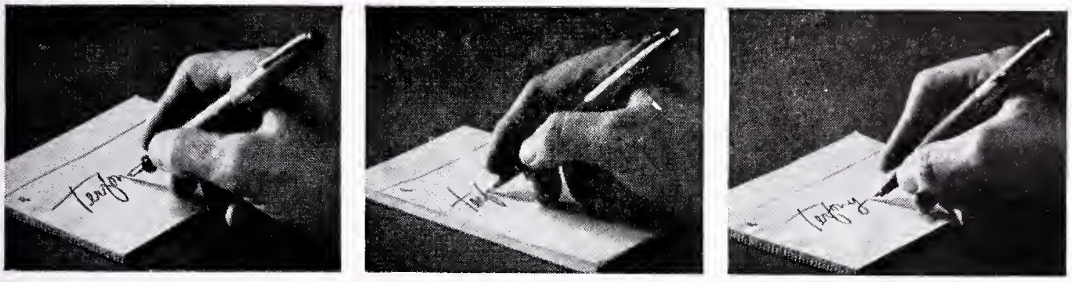
President Pang announced that Dr. Askey, AMA President will speak to the Society membership on September 26 at the Princess Kaiulani Hotel in the Robert Louis Stevenson room.

On "Drugs for Dooley," Dr. Pang requested Society members to bring the drugs to the Society office since Ken's Delivery Service went out of business.

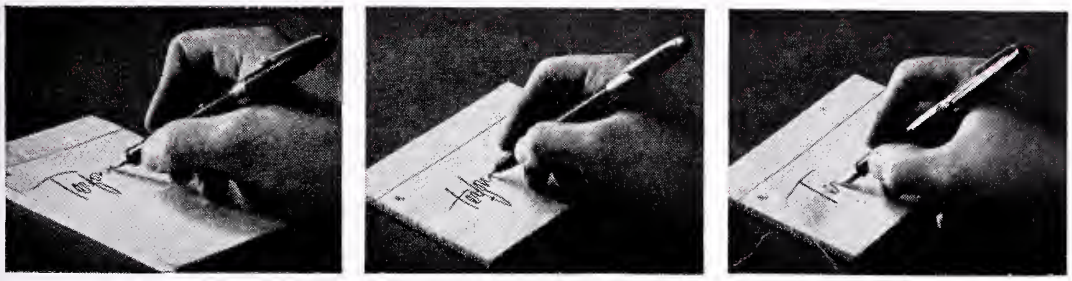
Dr. C. V. Caver reported that a letter from the local Cancer Society requested the Medical Society to oppose

(Continued on page 300)


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COUNTY SOCIETY REPORTS

(Continued from page 297)

the inclusion of Medical Research Program of the National Fund for Medical Education in the Honolulu Community Chest Fund Drive. This matter was referred to the Public Service Committee which met once with the representatives of the local Cancer Society and once with the Honolulu Community Chest. Dr. Caver stated that since the Board of Governors are meeting in the third week of September and the drive is about to begin he is bringing the matter on the floor. Dr. Caver then briefly covered the highlights of his committee's findings. A motion that the Honolulu County Medical Society inform the Honolulu Community Chest of its opposition to the inclusion of the Medical Research Program of the National Fund for Medical Education in the Fund Drive was made by Dr. C. V. Caver, seconded and unanimously passed.

Mr. Kennedy reported that the incorporation of the Society and the granting of statehood to Hawaii has necessitated some technical changes in the Bylaws. Besides these changes numerous grammatical changes have been made, therefore, rather than taking each change individually, the entire Bylaws has been circulated for approval. Dr. Pang pointed out that according to the amendment procedures, the proposed changes must be read at a meeting prior to the meeting in which final action is to be taken and that a copy of the proposed changes is circulated 10 days prior to the meeting in which final action is to be taken. A motion that the Bylaws as circulated be considered read throughout was made by Dr. Pershing Lo, seconded and passed.

O. D. PINKERTON, M.D.
Secretary

COUNCIL MEETING

(Continued from page 294)

ACTION:

It was moved and seconded that the committee's recommendation be accepted and a biographical sketch be submitted to "Postgraduate Medicine" for publication.

A. H. ROBINS AWARD

At the March 4, 1960, meeting the Council approv of the proposed Robins' award to be presented by t HMA at its annual meeting to the physician chosen having contributed the most to the community. T award, a plaque, will be available for our next meetin

ACTION:

It was moved and seconded that the President appoint a committee to look into the matter of making a selection and report back to the Council at its next meeting. The motion passed unanimously.

BRONZE PLAQUES

It was noted that bronze plaques are available f presentation by medical societies to officers who me special commendation. Also bronze rosters are availab on which the names of each president can be inscribe

ACTION:

It was moved and seconded that the treasurer look into this matter and report back to the Council at its next meeting. The motion passed unanimously.

Dr. Hartwell moved that the Council recommend the appointment of Dr. William Stevens as chairman of the Public Relations Committee, but since this appointment had already been made by Dr. Cushnie, no action was taken on the motion.

The meeting was adjourned at 10:25 P.M.

RODNEY T. WEST, M.D.
Secretary



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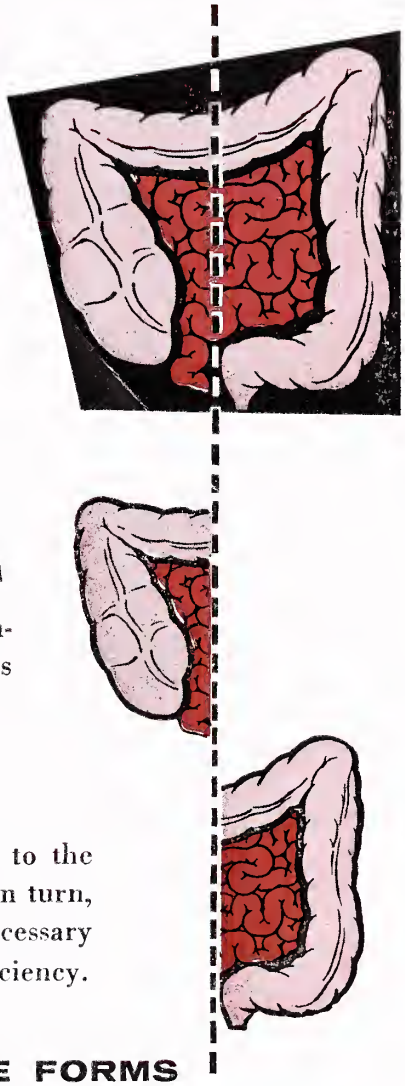
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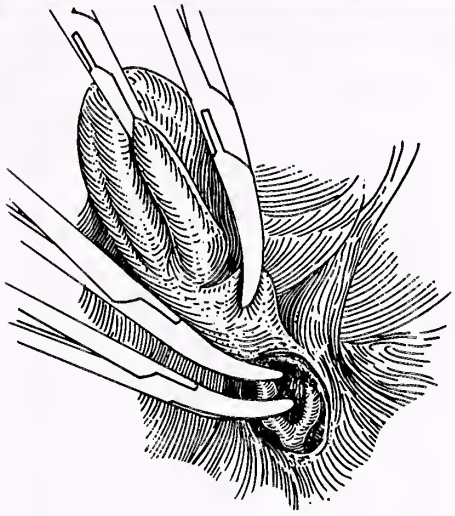
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Source: Farris, J. M., and Smith, G. K.: M. Clin. North America *43*:1133 (July) 1959.

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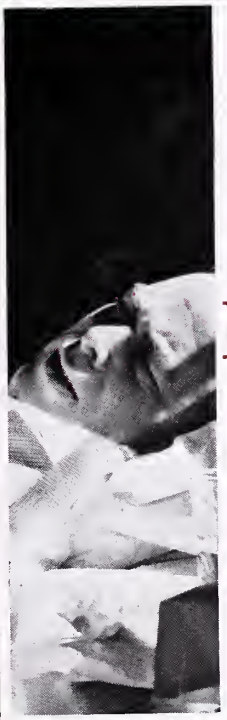
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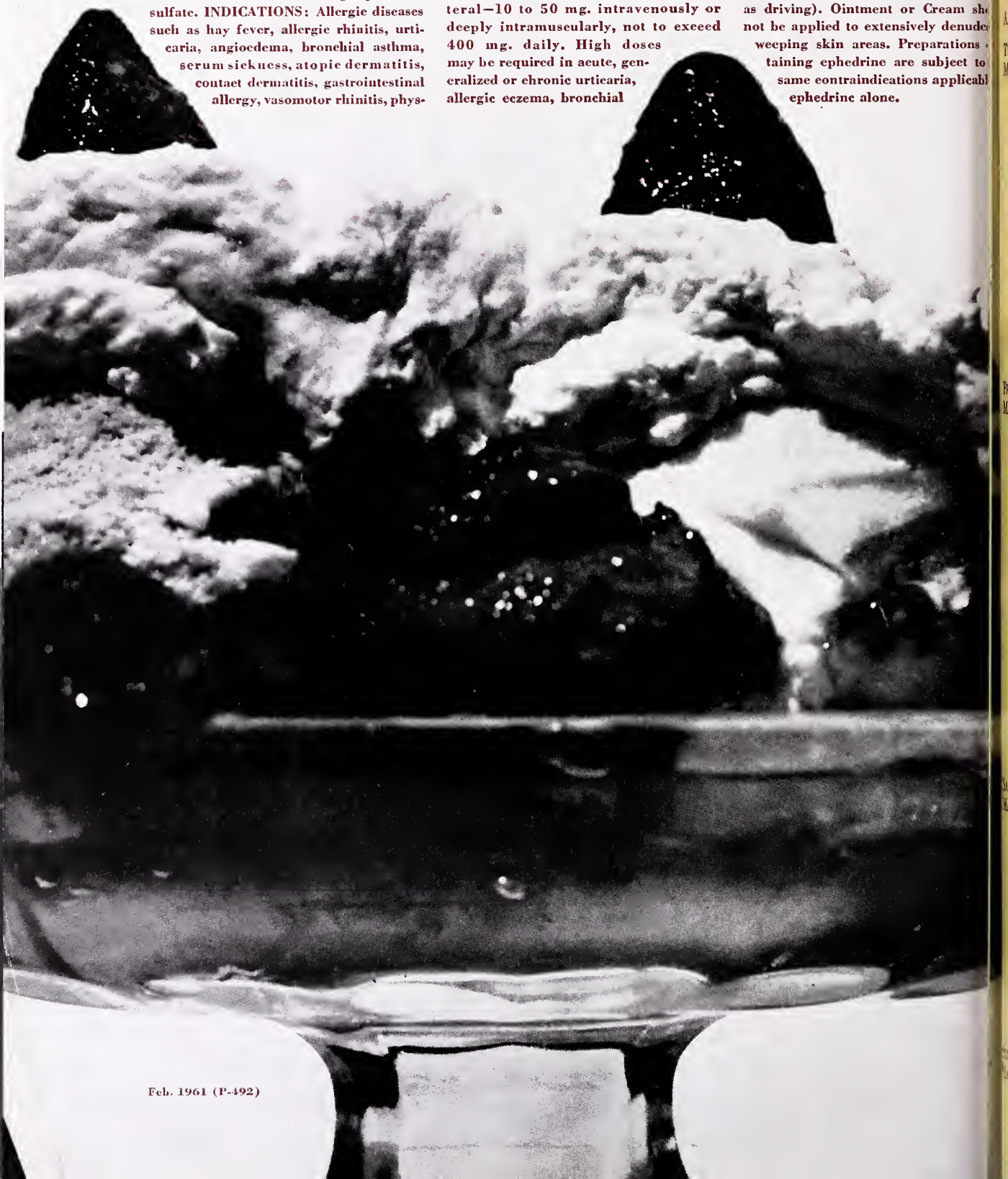
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Feb. 1961 (P-492)

HAWAII MEDICAL ASSOCIATION
105th ANNUAL MEETING
HONOLULU, HAWAII • MAY 4-7, 1961

Registration at the Princess Kaiulani Hotel, 120 Kaiulani Ave., Honolulu

Thursday, May 4—6:45-10:00 A.M. and 7:00-8:00 P.M.
Friday, May 5—6:45-10:00 A.M. and 7:00-8:00 P.M.
Saturday, May 6—7:00-10:00 A.M.

Registration Fee—$15.00

Wednesday, May 3

All breakfast and scientific sessions will be held at the Diamond Head Annex of the Princess Kaiulani Hotel.

THURSDAY MAY 4	7:00 A.M.	Breakfast ($2.00)
	7:30 A.M.	Panel on *Emergencies in the New Born* MODERATOR: Dr. Wilhelmina Haake PANELISTS: Drs. Jeannette Chang, George M. Ewing, William F. Moore, Jr., Allan C. Oglesby
	8:30 A.M.	Intermission to view exhibits
	9:00 A.M.	Panel on *Poisoning* MODERATOR: Dr. Richard K. B. Ho PANELISTS: Drs. Robert T. S. Jim, James L. Mertz, Calvin C. J. Sia, Donald T. Smith, Paul Y. Tamura
		• • •
	1:00 P.M.	House of Delegates Meeting at the Mabel L. Smyth Building
		• • •
	7:30 P.M.	*Chemotherapy in Cancer* by Dr. John W. Cline
	8:15 P.M.	Intermission to view exhibits
	8:45 P.M.	Paper by Dr. Walter C. Alvarez
FRIDAY MAY 5	7:00 A.M.	Breakfast ($2.00)
	7:30 A.M.	Panel on *OB-Gyn Emergencies* MODERATOR: Dr. Paul F. McCallin PANELISTS: Drs. George Goto, H. James Lambert, Jr., Gail G. L. Li, John M. Ohtani
	8:30 A.M.	Intermission to view exhibits
	9:00 A.M.	Panel on *Trauma* MODERATOR: Colonel Carl W. Hughes PANELISTS: Drs. Scott C. Brainard, Ralph B. Cloward, Robert G. Johnston, Rowlin L. Lichter
		• • •
	1:00 P.M.	House of Delegates Meeting (continued), Mabel L. Smyth Memorial Building
		• • •
	7:30 P.M.	Presidential Address by Dr. Edward F. Cushnie
	7:40 P.M.	Presentation of Robins Award
	7:45 P.M.	Introduction of new officers
	7:50 P.M.	Intermission to view exhibits
	8:15 P.M.	Paper by Dr. Walter C. Alvarez
	8:45 P.M.	*Diagnosis and Treatment of Carcinoma of the Stomach* by Dr. John W. Cline
SATURDAY MAY 6	7:00 A.M.	Breakfast ($2.00)
	7:30 A.M.	Panel on *Medico-Surgical Emergencies* MODERATOR: Dr. Lloyd M. Nyhus PANELISTS: Drs. Scott C. Brainard, Frank J. Bruce, Patrick T. Lai, Theodore T. Tomita
	8:30 A.M.	Intermission to view exhibits
	9:00 A.M.	Panel on *Medical Emergencies* MODERATOR: Dr. Walter C. Alvarez PANELISTS: Drs. Raymond deHay, S. R. Horio, Elmer C. Johnson, Bernard J. B. Yim
		• • •
	6:00 P.M.	Cocktails and Dinner Dance ($8.50) Oahu Country Club, dinner jackets optional
SUNDAY MAY 7	6:30 A.M.	Breakfast at Oahu Country Club (included in Tournament Fee)
	7:00 A.M.	Annual Golf Tournament, Oahu Country Club ($10.00)
	1:00 P.M.	Picnic for registered physicians only at the home of Dr. Harry L. Arnold, Jr., 4992 Kahala Ave., Honolulu ($3.00)

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on the pathogenesis of pyelonephritis:

"An inflammatory reaction here [renal papillae] may produce sudden rapid impairment of renal function. One duct of Bellini probably drains more than 5000 nephrons. It is easy to see why a small abscess or edema in this area may occlude a portion of the papilla or the collecting ducts and may produce a functional impairment far in excess of that encountered in much larger lesions in the cortex."[1]

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References: 1. Schreiner, G. E.: A.M.A. Arch. Int. M. **102**:32, 1958. 2. Freedman, L. R., and Beeson, P. B.: Yale J. Biol. & Med. **30**:406, 1958. 3. Rocha, H., et al.: Yale J. Biol. & Med. **30**:341, 1958.

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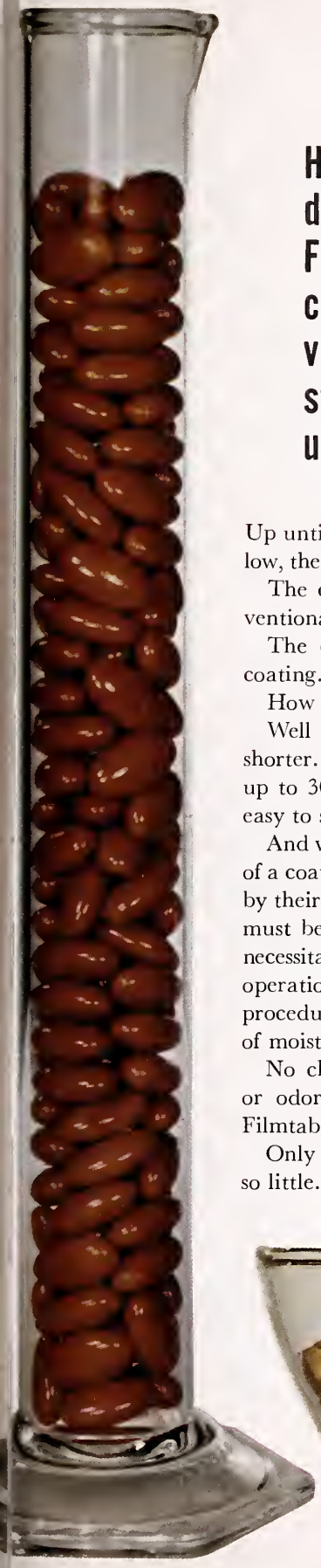
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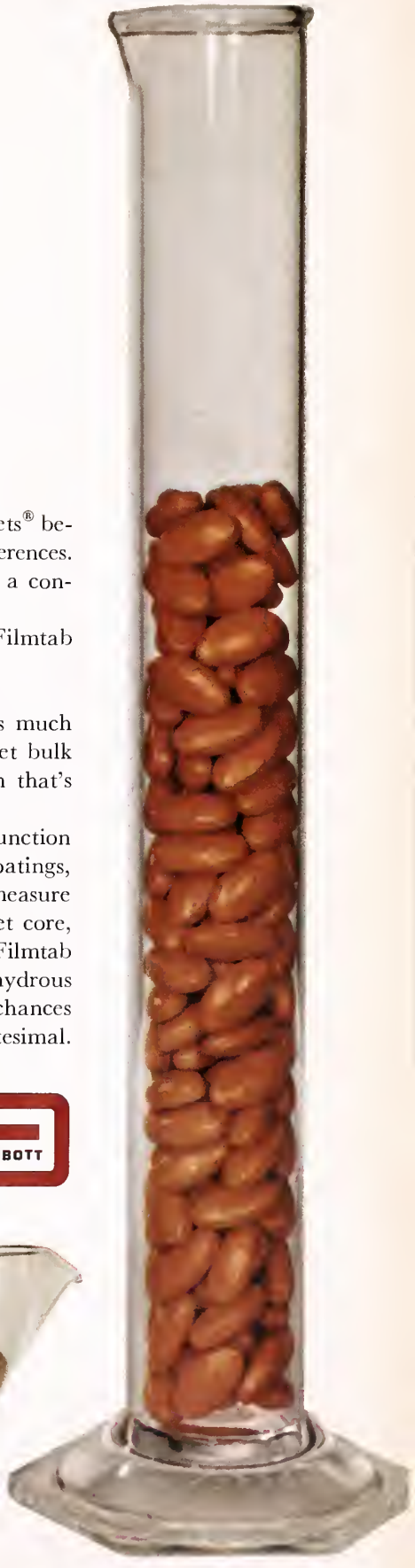
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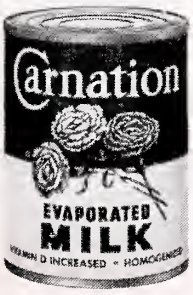
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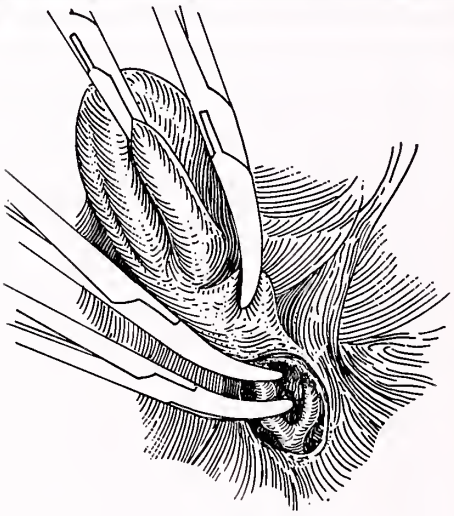
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Source: Farris, J. M., and Smith, G. K.: M. Clin. North America *43*:1133 (July) 1959.

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References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Ford, R. V.: Current Therap. Res. 2.92 (Mar.) 1960.

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references: (1) Howell, C. M., Jr.: North Carolina M. J. *21*:194-195 (May) 1960. (2) Lish, P. M.; Albert, J. R.; Peters, E. L., and Allen, L. E.: Arch. internat. pharmacodyn. *126*:1960, in press. (3) Clinical Research Division, Mead Johnson & Company. (4) Wahner, H. W., and Peters, C. A.: Proc. Staff Meet. Mayo Clin. *35*:161-169 (March 30) 1960. (5) Crepea, S. B.: J. Allergy *31*:283-285 (May-June) 1960. (6) Crawford, L. V., and Grogan, F. T.: J. Tennessee, M.A. *53*:307-310 (July) 1960. (7) Spoto, A. P., Jr., and Sieker, H. O.: Ann. Allergy *18*:761-764 (July) 1960.

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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

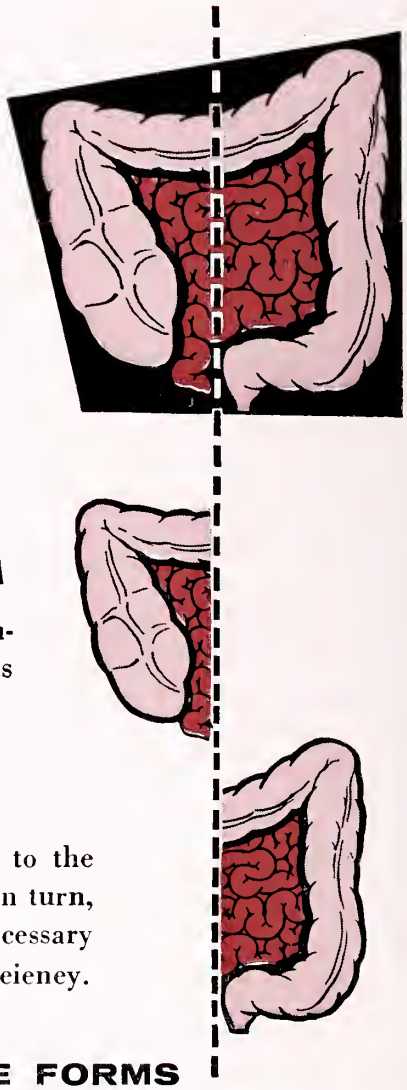
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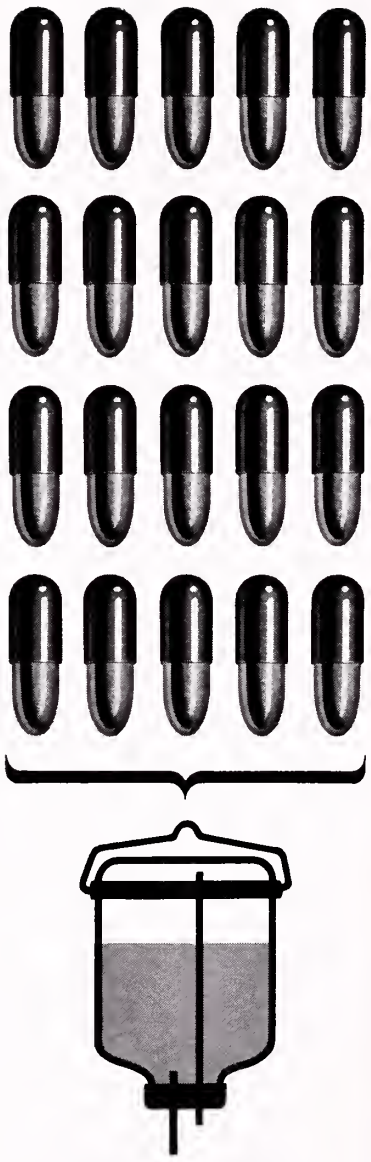
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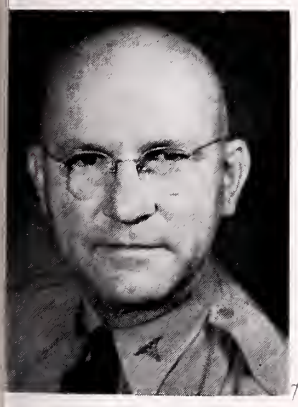
Man's ingenuity in damaging himself is exceeded only by the ingenuity of other men in repairing the damage

A Symposium of Unusual Trauma Cases

COLONEL WARNER F. BOWERS, MC,* and

COLONEL CARL W. HUGHES, MC, Honolulu

THE FOLLOWING brief case reports exemplify causative mechanisms, diagnostic hints, and therapeutic principles which require frequent emphasis. Summary of the pertinent points allows these observations:



COL. BOWERS

1. The need is for accurate history and physical examination, correct appraisal of the initial status, careful observation of hospital course, understanding of causative mechanisms, proper interpretation of changes as they occur, and timely treatment aimed at specific results.
2. Large amounts of blood or plasma volume expanders, or both, are required for resuscitation, during operation, and postoperatively. The general tendency is to give too little.
3. Colonic injuries require exteriorization usually: proximal diverting colostomy for lesions which cannot be exteriorized and consideration of resection for cecal and ascending colon injuries. Other hollow viscera are treated by primary closure.
4. Reliance should be on good technique and adequate surgical judgment rather than antibiotic administration.
5. Early operation for the pulseless extremity is mandatory if extremities are to be saved.
6. Small bowel perforation is difficult to diagnose in cases of blunt abdominal trauma because free air is rare, white blood count usually is not high, pulse and temperature tend to remain low, and peritoneal irritation most often is minimal.
7. Chest compression may cause maniacal behavior from cerebral anoxia and petechiae, neurological changes from the same mechanism, subconjunctival and retinal hemorrhages, and a purple mask from venule distention.
8. Damage of soft tissue from gunshot wounds depends on velocity of the missile and its blast effect. Blank cartridges may cause extensive blast effect even though there is no missile.
9. Multiple injury cases require careful teamwork to assure prompt and proper treatment with priority gauged by the patient's needs rather than the specialty concerned. Operation during severe shock may be necessary if resuscitation fails to control blood loss.

* Chief of the Department of Surgery, Tripler U. S. Army Hospital.
This series of presentations was prepared at the suggestion of the Committee on Trauma of the Hawaii Chapter of the American College of Surgeons, James W. Cherry, M.D., Chairman.

Treatment of Gunshot Wounds, Missile and Blank

CAPTAIN GEORGE L. JOHNSON, MC

Gunshot wounds may be caused by missiles or blanks, with the resulting damage being as different as the force that produces them.



CAPT. JOHNSON

Surgeons are relatively familiar with the external appearance, the tissue damage and the general treatment of missile wounds. The wound of entrance is small and usually circular. The margin is slightly irregular and may be inverted somewhat from the force of entry. The wound of exit, if present, is larger than the wound of entrance, giving the general appearance of a blast effect from its ragged, irregular margin and deeper defect.

The tract through the body may be direct or erratic as the missile is deflected in its journey by various obstacles such as bone or dense fascia.

The relatively innocent appearance of the wound of entrance is misleading in determining the amount of damage caused in the course of the missile through the body. As a result of tumbling, wobbling, compression, and suction effect by the missile, the soft tissue damage can be very extensive. Bones can be shattered yet never be touched by the missile itself. Foreign material can be carried or sucked into the wound yet not be apparent by external examination.

The treatment of a wound of an extremity with no bone involvement is well established and simple, consisting of debridement of the wounds of entrance and exit and thorough irrigation to remove loose tissue and foreign material. The wounds are left open for drainage with a delayed closure in four to five days if there has been no drainage.

The following two case histories will illustrate the care of these injuries.

CASE 1: A 28-year-old man accidentally shot himself in the right forearm with a .22 caliber automatic pistol. There was no motor, sensory, or vascular defect. The wound of exit was approximately two cm in diameter. Under local one per cent xylocaine anesthesia, debridement and irrigation of the wound was accomplished. Delayed closure of the wounds of entrance and exit was performed five days after entry with primary healing.

CASE 2: A 20-year-old man was accidentally wounde in the right lower leg with a .22 caliber revolver. Peripl eral pulses, sensory and motor activity were norma Debridement of the wounds and thorough irrigation w performed under spinal anesthesia. The wounds we left open to be closed in five days with primary healin

In these two cases, low velocity missiles cause very localized tissue damage and extensive d bridement was not necessary.

Gunshot wounds resulting from blank ammun tion are infrequently seen. These injuries diff from missile injuries in the extent of damage an in the early management. The damage is mo superficial than from live ammunition and th tissue contamination with foreign material and th blast effect are greater, making more extensiv initial debridement necessary.

Injury of this nature by necessity occurs at clos range, which means that foreign material fro the powder charge, wadding, packing, and clot ing is blasted into the tissues. The spread is periph eral as well as deeper into the wound. The d bridement requires fairly wide sharp excision i order to remove all the foreign material and d vitalized tissue. Closure may be delayed longer.

CASE 3: A 24-year-old man received a blank gunsh wound in the upper part of the right forearm while o maneuvers. Extensive debridement under local anesthesi was necessary in order to remove completely the foreig material. The deep fascia was debrided and left oper A delayed closure of an 8x4x1 centimeter defect, usin local anesthesia, was performed in seven days. Th wound healed primarily.

CASE 4: A 38-year-old man was wounded in the righ calf by an M-1 blank. Examination revealed an extremel dirty, ragged wound in the upper portion of the righ calf in the region of the head of the fibula. There was n circulatory or neurological deficit. A thorough debride ment and irrigation was carried out with a Penrose drai brought out through a dependent stab wound. In orde properly to debride the wound, a considerable amoun of damaged muscle had to be removed. Delayed closur of the wound was accomplished on the sixth day wit primary healing.

The following case is presented to demonstrat that primary closure frequently fails. In this par ticular instance this possibility was recognized bu as the digital nerves of two toes were exposed primary skin graft was performed in order to gai coverage.

CASE 5: A 19-year-old man sustained a wound be tween the right second and third toes by a .30 calibe blank cartridge while resting the rifle's muzzle on hi

oot. At the time of debridement the digital nerves were ound to be exposed to a considerable length. A split hickness skin graft was applied to cover the nerves. The graft failed because of drainage. After adequate reparation the wound was grafted the second time 20 ays after injury with healing occurring without incident.

The basic principle of the initial treatment of unshot wounds is debridement and thorough irrigation. Wounds received from blank ammunition require more extensive debridement than those of low velocity missile ammunition because of the greater contamination by foreign material even though the wound is usually more superficial. Primary closure of either type of wound is contraindicated.

Difficulty in Diagnosing Perforation of Mid-Small Bowel

CAPTAIN RICHARD B. HELFRICH, MC

Acute peritoneal soilage is generally regarded s being a catastrophic, highly symptomatic event. The peritonitis of upper gastrointestinal tract etiology such as perforation of peptic ulcer is chemical in nature and produces profound symptoms and signs; likewise, bacterial peritonitis from colonic perforation is characterized by an equally dramatic clinical picture.



CAPT. HELFRICH

Lying between the duodenum and the colon, the jejunum and ileum occupy a position that is physically and clinically characterized by relative diagnostic inaccessibility. This phenomenon, whether due to the less acid, less bacterially contaminated contents, or to the protecting apron of the omentum, or both, is frequently a source of diagnostic difficulty and consequent increased patient morbidity.

The following cases are illustrative:

CASE 1: A 52-year-old Caucasian man was admitted with left lower quadrant pain of two days' duration. He had been in excellent health until three weeks previously, when in an automobile accident he received lacerations of both knees, left upper arm, and forehead, and a contusion of the right ankle. He was not aware of any abdominal injury. Subsequent to the accident he was hospitalized for two weeks, being discharged a week before we saw him. His bowel habits during this time were normal and he was aware of no abdominal pain until three days before admission, when he noted sharp continuous pain in the left lower quadrant without radiation, gradually becoming more intense.

Oral temperature was 99.6° F., pulse 110, blood pressure 140/78. His recent lacerations were all healing well without evidence of infection. There was a palpable tender mass in the left lower quadrant with a slight skin discoloration over this area. The bowel sounds were normal, as was rectal examination. Admission white blood count was 11,100 with 70 per cent neutrophils. The hematocrit was 31. Urinalysis, chest x-ray, and abdominal films were normal.

Because it was thought that the patient's past history and physical findings were most compatible with diverticulitis with perforation, the patient was started on nasogastric suction, intravenous fluids, and antibiotics. Sigmoidoscopy shortly after admission was normal to a distance of 15 centimeters, at which point the lumen could not be visualized because of an apparent extrinsic mass compressing the sigmoid.

The patient responded well, the nasogastric tube was removed and he was started on soft diet after five days. After five more days the patient again complained of crampy left lower abdominal pain and there was abdominal distention. At this time the mass in the left lower quadrant appeared to be more tender and somewhat larger. Coincident with the onset of increased pain and tenderness, the patient's oral temperatures were noted to be 100 to 101° F. Still, with the impression of diverticulitis with perforation, transverse colostomy was performed two weeks after admission in order to divert the fecal stream. Following this procedure, the patient became afebrile and was without discomfort, although the palpable mass remained. One month following construction of the colostomy, at exploratory laparotomy, dense adhesions of the small bowel to the anterior abdominal wall and to the sigmoid colon were noted. It was apparent that there had been a perforation of the small intestine, with spontaneous sealing of the perforation against the sigmoid. The procedure performed was resection of the involved small bowel and sigmoid colon and end-to-end anastomosis. The postoperative course was uneventful. After three weeks the colostomy was closed.

It is assumed that an undiagnosed small bowel perforation sustained at the time of initial injury did not manifest itself sufficiently to be diagnosed. Only after repeated peritoneal contamination had occurred was an intraperitoneal inflammatory process suspected. The proximity of the inflammation to the sigmoid colon suggested this viscus was primarily responsible. Had the diagnosis been suspected initially, prompt laparotomy would have decreased the patient's morbidity significantly.

This case illustrates well the difficulties inherent in the management of blunt abdominal trauma to the small bowel.

CASE 2: This 12-month-old Caucasian girl was admitted at 2000 hours, having been shot in the right flank at approximately 1500 hours on the day of admission. The parents stated that a sibling discharged a .22 caliber pellet rifle which was lying on the mother's lap, the pellet striking the child's right flank immediately above the wing of the ilium. At the time of injury the child manifested only momentary discomfort but approximately 30 minutes later, the child vomited. Approximately four hours after injury the parents became aware of an elevated temperature, following which the child was seen at the local dispensary. X-ray examination showed the pellet to be in the abdomen.

Examination on admission showed temperature of 104° rectally, pulse of 160. There was a small puncture wound over the right iliac crest and the abdomen was thought to be diffusely tender; however, the child was quite irritable and examination was difficult. There were no palpable masses. Rectal examination was normal. White blood count was 12,700 with 57 neutrophils, 40 lymphocytes, 2 monocytes, and 1 eosinophil. Hematocrit was 37. Urinalysis was normal. Chest x-ray was normal. Abdominal film showed the pellet in the abdomen. There was no evidence of free intraperitoneal air.

After adequate preparation which included intravenous fluid and antibiotics as well as antipyretics, the child underwent exploratory laparotomy at which time six perforations of the mid-ileum were found and closed by a double-layer silk technique. The missile was found within the omentum and was removed. The postoperative course was unremarkable. Her temperature was normal 48 hours following surgery and remained normal for the remainder of her hospitalization. She was started on oral intake on the third postoperative day and was discharged on the eighth postoperative day.

It is remarkable that the considerable soilage by ileal contents was not manifested more dramatically. The few symptoms, the lack of shock, and the relatively low leukocytosis seem out of proportion to the damage produced by the missile.

This case also points the need for laparotomy in all perforating abdominal injuries regardless of the patient's clinical status or the small size of the pellet.

Small-Vessel Hemorrhage Requiring Thoracotomy

CAPTAIN LESTER F. WILLIAMS, JR., USAF (MC)

Although the treatment of a given patient always requires individualization, general principles remain the basis upon which all therapy depends. Abdominal trauma usually requires exploration, in contrast to thoracic trauma, which usually can be treated conservatively. One exception to the rule of conservatism in thoracic trauma is active arterial bleeding, which often is from major vessels but can be from small vessels.



CAPT. WILLIAMS

CASE 1: A 21-year-old man was admitted one hour after sustaining multiple stab wounds. On admission the patient was in shock with a pulse of 110 and blood pressure of 60/20. Physical examination was consistent with shock and a right hemothorax, there being a two-centimeter stab wound at the right sternal border between the third and fourth costal cartilages. Immediate right thoracentesis was productive of 625 cc of blood. Replacement was begun with two units of dextran and was continued with whole blood. Continued active bleeding was manifest by unstable vital signs in spite of replacement and by the re-accumulation of 700 cc of blood in the right chest.

At right thoracotomy, the preoperative impression of division of the right internal mammary artery was confirmed. Both ends of the artery were actively bleeding and required ligation. The patient tolerated the operative procedure well and his hospital course was satisfactory. He received two units of dextran and 5,500 cc of whole blood.

CASE 2: A 19-year-old man was admitted one hour after sustaining a stab wound in the left upper quadrant of the abdomen, the wound being just below the costal margin at the anterior axillary line. Physical examination revealed impending shock and a left hemothorax. Replacement was begun with one unit of dextran and continued with whole blood. A left thoracentesis was productive of 510 cc of blood.

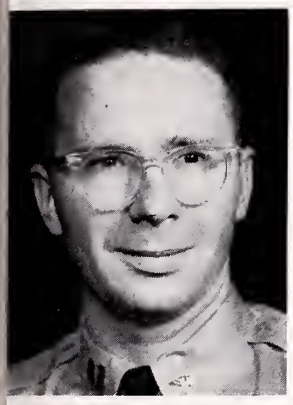
Because of continued active bleeding manifest by tachycardia, dropping hematocrit, and a progressive left hemothorax, a left thoracotomy was performed. The chest contained approximately 2,500 cc of blood with active bleeding coming from a laceration of the ninth intercostal artery. A rent was present in the dome of the diaphragm and on abdominal exploration, a 1.5 cm laceration of the spleen without active bleeding was found. The patient tolerated the operative procedure well and his hospital stay was uneventful. He received one unit of dextran and 3,000 cc of whole blood.

Although one principle of thoracic trauma is that conservative therapy usually is adequate, active arterial bleeding requires surgical control in the chest as elsewhere. Two cases which demonstrate the need for urgent surgery are presented. These cases are unusual, in that the bleeding followed small stab wounds which divided relatively small vessels, the internal mammary artery and an intercostal artery.

Severe Multiple Injuries

Captain Francis J. Heck, MC

A case of multiple injuries required operative resuscitation and prolonged hospital care by several services before eventual recovery was achieved.



CAPT. HECK

A seven-year-old Caucasian boy run over by a truck was found conscious but unable to move, in a prone position, with a tire mark running diagonally across his back from right waist to left shoulder.

On arrival at Tripler U. S. Army Hospital one hour later, he was breathing rapidly with labored respirations, obviously in shock (blood pressure 60/40, pulse 140). There were left shoulder and right thigh deformities with shortening. The patient was unable to move his left leg but could feebly move the right leg. Poor breath sounds, tympany, and a paradoxical retraction were present in the left chest. There were no palpable abdominal masses and bowel sounds were normal. Sensation was intact. The penis was ecchymotic and the scrotum had a developing hematoma.

Resuscitation was begun with one unit of dextran followed by four units of whole blood in four hours through two ports, one by catheter in the left saphenous vein. Initial examination revealed acute gastric dilatation with the stomach in the left chest. Nasogastric suction was instituted. A Foley catheter was inserted into the urethra and pure blood drained freely and constantly from the catheter. Urethrogram showed the catheter to be displaced to the left of the bladder and the contrast medium to have infiltrated generally.

X-rays revealed fractures of the left humeral head, the left scapula, and the left fifth through eighth ribs in the mid-axillary line; ruptured left diaphragm and herniation of a dilated stomach into the left chest and collapse of the left lung with a small hemothorax; and fractures of both ilia, both pubic rami, the right ischium, and the right femur at the junction of the upper third, with overriding. The patient's abdomen remained flat and soft, suggesting no great degree of intraperitoneal hemorrhage.

In view of his failure to respond, his pulse remaining 135 and blood pressure 90 systolic, emergency measures to control hemorrhage were needed. At surgery rupture of the spleen was found, with rupture of the left diaphragm and herniation of the stomach into the left chest. Splenectomy was performed and the diaphragm repaired. A tear of the right internal iliac artery was found, with a large pulsating hematoma containing approximately 700 cc of blood. The right internal iliac artery was ligated to control bleeding. The bladder neck was found to be completely severed from the bladder, and the ends were approximated with a Foley catheter placed through the urethra. After control of the major bleeding points was accomplished, the patient's blood pressure and pulse became stabilized and remained so throughout the remainder of the procedure.

Postoperatively, the patient had a left thoracotomy tube under water-seal drainage, a suprapubic cystostomy, Foley catheter, and Penrose drains retroperitoneally near the right kidney and in the space of Retzius. Nine units of whole blood were given during the resuscitation and emergency surgery. A fluctuant hematoma was noted over the right flank and back postoperatively and no movement of the lower extremities was present.

Fourteen hours after injury, the pulse rose to 150 and the blood pressure was 90/60. Temperature was 102° F. axillary. The patient was incontinent of stool, and urine output was very poor. Sixteen hours after injury, he was irrational and semi-comatose. A tracheostomy was performed 30 hours after injury to facilitate care and to assist labored respirations and oxygen administration. Thirty-six hours after injury, the patient had a generalized convulsion and was treated with intravenous calcium gluconate. A fixed, dilated right pupil was present and the patient became completely unresponsive to painful stimuli. Thirty cc of 50 per cent glucose was given and the pupils became equal. Bilateral Babinski responses were present. Neurosurgical consultant felt the patient suffered bilateral lumbosacral injury and generalized cerebral dysfunction due to diffuse petechial hemorrhages of the brain and also due to electrolyte imbalance. Hyponatremia (sodium 110 mEq/L, chlorides 85 mEq/L) was treated with intravenous five per cent saline and the patient regained consciousness.

Massive edema of the scrotum and penis became evident and multiple aspirations with needles and enzyme instillations were used. Antibiotics and cortisone were begun, the latter being discontinued by the nineteenth hospital day. On the third hospital day the BUN was 85 mg per cent. Urinary output increased to approximately a liter per day.

Kirschner wire was placed through the right tibia for alignment of the fractured right femur. The fractured left humerus was treated with lateral skin traction.

Chest tubes were clamped on the fourth postoperative day and removed shortly thereafter. The abdominal wound healed uneventfully and the drains in the abdomen were removed. Tracheostomy was closed on the eleventh postoperative day. Left thoracentesis had to be performed postoperatively twice.

The patient's subsequent course was marked by repeated elevations of temperature. A large hematoma of the posterior back and right buttock with necrosis of the gluteus maximus muscle became evident on the eighteenth day, necessitating drainage on the twenty-fourth hospital day.

The patient was placed in a spica cast to allow continued treatment of the fractures while cleaning up an infected hematoma over the lumbar region and the right buttock region. Repeat debridement of the buttock area was necessary and split thickness skin graft was applied on the 60th hospital day and again on the 90th hospital day. The left foot was placed in a short leg cast to prevent foot drop. Adequate bone healing had occurred by the fifth hospital month and rehabilitation then was undertaken because of the scoliosis of the spine which had developed with marked lordosis.

Suprapubic catheter was removed in the sixth postoperative month. The patient developed urethral fistula and stricture which required several hospitalizations for dilatations and fistulectomy. The patient gradually regained partial urinary continence.

Gradual return of function and sensation occurred over the lower extremities but 21 months after injury the patient continued to have moderate generalized weakness of the lower extremities with marked weakness of the dorsal flexors of the right foot. At present, the patient is on continuing urological and physical therapy follow-up.

Traumatic Inguinal Hernia and Thrombosis of the External Iliac Artery Due to Blunt Trauma

CAPTAIN WILLIAM S. MOSKOVITZ, MC

Inguinal hernia due to direct accidental trauma is a rare entity. When combined with thrombosis of the external iliac artery due to disruption and inversion of the intima of the artery, it is indeed a rare condition. It is estimated that one out of every 10,000 hernias is due to direct violence. Because of the rarity of this condition, it is felt that report of this case is indicated.



CAPT. MOSKOVITZ

A 30-year old Caucasian male was admitted to Tripler U. S. Army Hospital after being involved in an accident in which he was thrown from an automobile. Physical examination revealed a belligerent, uncooperative man with multiple lacerations and abrasions of face, scalp, and extremities which were bleeding slowly. Blood pressure was 90/40, pulse 120, and respirations 30. A large mass in the left lower quadrant of the abdomen extended down into the inguinal and femoral regions as well as into the scrotum. It was partially reducible into the abdominal cavity. The skin over it was severely contused but intact. The left leg was cold and pulseless. Initial hematocrit was 41. X-rays revealed a fracture of the symphysis pubis and right acetabulum. Catheterized urine specimen was clear.

The wounds were dressed to obtain hemostasis and after resuscitation, the abdomen was explored through a midline incision. There was marked hemorrhage in the subcutaneous tissue with complete disruption of the left rectus sheath. The pubic fracture was palpable through this defect. There was no free blood in the peritoneal cavity, so immediate attention was given to the left iliac artery.

To examine the external iliac, a hernia of the sigmoid colon through the peritoneum into the femoral canal had to be reduced. There was good pulsation of the common and external iliac artery down to the pelvis, where the fracture was noted. At this point, the artery was hard and occluded by a thrombus. A second incision was made over the femoral canal extending across the inguinal area in order adequately to approach the external iliac artery just as it leaves the pelvis. It was noted that the internal oblique had been completely torn free and the external oblique aponeurosis was shredded. The spermatic cord was lying free beneath the skin and swollen with hematoma.

Approximately 1.5 centimeters of the external iliac vessel was resected and end-to-end anastomosis performed, with immediate return of pulsations to the left lower extremity. Systematic exploration of the peritoneal cavity revealed only a small tear in the mesentery, which was repaired. The torn serosa of the herniated sigmoid also was repaired. The peritoneal tears in the floor of the pelvis, and the inguinal, and femoral areas were repaired with chromic catgut. The midline incision was closed with wire retention sutures. The exposed surface of the fractured pubis was rongeured where it touched the external iliac vessel and fat was placed over this area to protect the vessels. The internal oblique muscle was repaired and the external oblique closed over the cord. Drains were placed in the inguinal area, scrotum, and space of Retzius. The face and scalp wounds were closed after debridement. A severe laceration over the left elbow was debrided and a delayed primary closure performed five days later.

Postoperatively, the patient did quite well. All wounds healed primarily. Because of his pelvic fractures he was kept on bed rest but had physical therapy for his upper and lower extremities. In three weeks the patient was fully ambulatory on crutches without weight bearing because of the right acetabular fracture. His left leg had good pulses and was asymptomatic on standing and walking. There was no evidence of recurrence of his hernia. He then was transferred to the mainland with recommendation that he should not bear weight on his right lower extremity for three months.

We have presented a case of severe trauma with multiple injuries, including a traumatic hernia, thrombosis of the external iliac artery, fractures of the symphysis pubis and right acetabulum, and multiple lacerations of the face, scalp, and extremities. A logical approach to management of patients with multiple injuries such as this has been presented. Resuscitation and early exploration are mandatory if the patient is to survive and have viable extremities.

Acute Superior Vena Caval Compression

Captain William F. Quigley, MC

Acute traumatic compression of the superior vena cava (traumatic asphyxia) is a bizarre clinical curiosity. The syndrome is secondary to a sudden increase in pressure distributed through the superior vena cava and its tributaries, remarkably free of valves and, therefore, most susceptible to venous backflow. Obvious dilatation of larger veins is not seen; but engorgement of deep and superficial venules and capillaries imparts a deep blue color to the skin of the head, neck, and upper thorax. Edema, venous hemorrhage, and infarction also occur. Thus petechiae, subconjunctival and retinal hemorrhages, as well as neurologic changes, become manifest.



CAPT. QUIGLEY

In those cases which survive the initial compression, prognosis for life is good, but there are occasional persistent ocular or neurologic deficits. Associated injuries are uncommon, the most frequent entities being fractured ribs, hemothorax, pneumothorax, and traumatic wet lung. Treatment is supportive.

Recently at Tripler U. S. Army Hospital we have treated two cases of traumatic asphyxia.

Case 1: A 34-year-old Negro man was working on his back beneath an automobile when the jack supporting it collapsed, thus pinning his anterior thorax with the full weight of the car. Compression was continuous for ten minutes, several moments of which he was unconscious. At the time of admission he was awake and oriented, complaining of severe anterior chest pain.

Physical examination revealed a purplish hue to the skin of the face and neck. There were marked bilateral subconjunctival hemorrhages and venous engorgement of the retina. Vital signs were within normal limits. There was tenderness over the anterior thorax from the second to the sixth ribs bilaterally and a general muscular weakness of the left upper extremity with hypesthesia in the distribution of the left ulnar nerve.

There were posterior fractures of the third and fourth ribs on the left and a slight pleural reaction in the left costophrenic angle which appeared on the fourth day and subsequently subsided.

The patient received supportive care including blow bottles to encourage deep breathing. Oxygen was not necessary. Within 30 days recovery was complete but for minimal subconjunctival hemorrhages and a persistent hypesthesia in the course of the left ulnar nerve. Full motor function had returned.

The clinical findings in the left upper extremity suggested a peripheral nerve lesion, based on stretching of the left brachial plexus.

Case 2: A 22-year-old Negro man was repairing the forward landing gear of a jet fighter when the plane collapsed, retracting both wheel and patient into the forward landing gear well. The patient's head and shoulders were within the wheel housing and the wheel itself compressed his upper abdomen and anterior thorax. He rapidly lost consciousness and was impinged for 20 minutes.

At the time of admission he was raving and maniacal. There was purplish discoloration of the head, neck, anterior thorax, and upper extremities. Petechial hemorrhages could be seen on the palate and pharyngeal mucosa. There was bilateral proptosis and severe subconjunctival hemorrhages. No spontaneous movements of right upper and both lower extremities could be seen. Deep tendon reflexes were absent in the right upper extremity but normal in both lower extremities. No pathologic reflexes were present, but abdominal and cremasteric reflexes were absent. Sensory examination was impossible.

The initial chest x-ray revealed acute gastric dilatation which was relieved successfully by Wangensteen drainage. Wangensteen drainge again was necessary in order to relieve a severe paralytic ileus. An indwelling Foley catheter initially was placed and later removed without further bladder dysfunction. X-rays of the cervical, dorsal, and lumbar spines revealed no evidence of fracture or dislocation.

Within 24 hours the patient was oriented and rational, beginning to use all extremities. However, as use of the lower extremities improved, spasticity developed accompanied by pathologic toe signs and ankle and patellar clonus. A poorly defined belt-like area of hypesthesia developed in a dermatome area limited by D8 and L5. There was persistent generalized muscular weakness in the right upper extremity with absent deep tendon reflex but no sensory deficit.

On the fourteenth hospital day, 800 cc of a serosanguineous effusion was aspirated from the right pleural space. Progressive physiotherapy and ambulation were employed and within 40 days he could walk quite well with a cane. There was diminished spasticity, but muscular weakness continued in the right upper extremity.

The original maniacal behavior probably was due to temporary cerebral anoxia and diffuse petechial hemorrhages.

Two possible explanations of the spastic paraparesis are worthy of note. A sagittal sinus thrombosis involving the precentral motor cortex was considered but could not explain the band of abdominal hypesthesia. A more inviting explanation is venous infarction of the spinal cord, wherein both motor and sensory changes can be understood.

Again, the neurologic changes in the right upper extremity suggest a peripheral nerve lesion, probably caused by a stretch of the brachial plexus.

A Complicated Penetrating Wound of the Abdomen With Injury to the Colon and Small Intestine

CAPTAIN KENNETH B. BONILLA, MC

The time proven principles for the care of wounds of the intestines should not be forgotten simply because of the adjunctive use of intestinal sterilization techniques. Antibiotics certainly have made a marked improvement in the mortality and morbidity figures for wounds of the colon as well as for elective surgery of the colon, but too much reliance can be placed on their use.



CAPT. BONILLA

Wounds of the small intestine can usually be handled by simple debridement and closure, or occasionally by resection with primary anastomosis. Wounds of the colon, however, should be considered contaminated and, therefore, treated somewhat differently. Injuries of the right colon usually are dealt with by right colectomy and primary ileotransverse colostomy. Wounds of the transverse colon most often can be exteriorized as a colostomy, with later end-to-end closure. Wounds of the left colon and sigmoid should be treated by closure of the perforation, plus a diverting proximal colostomy or occasionally by exteriorization of the loop. A loop colostomy is not considered diverting, for the loops should be separated. A cecostomy is not considered adequate for fecal diversion.

A 19-year-old man was admitted 36 hours after being shot in the left lower abdomen with a .45 caliber pistol, accidentally discharged at close range. There was no wound of exit. An exploratory laparotomy at another hospital, four hours following the trauma, had disclosed a single wound of the sigmoid colon and four perforations of the distal ileum. The missile had lodged in the sacrum and a moderate retroperitoneal hematoma was noted.

Initial treatment consisted of resection of six inches of ileum and end-to-end anastomosis with a single layer of 4-0 silk sutures. The wound of the sigmoid colon was closed with a single layer of similar suture material. Three intraperitoneal drains were placed in the pelvis. The wound of entrance was debrided and closed without drainage.

Postoperatively, the patient did poorly, had continued fever and peritonitis and abundant foul-smelling drainage from the intraperitoneal drain tracts. He was returned to surgery four days following injury where it was discovered that the sigmoid repair had broken down and a second perforation was discovered on the mesenteric border of the sigmoid colon. There was sufficient length of the sigmoid mesentery so that the involved segment was exteriorized and divided in 48 hours. The ileal anastomosis was satisfactory.

The retroperitoneal hematoma became infected, and osteomyelitis occurred in the missile tract of the sacrum. This was debrided and curetted posteriorly, the bone fragments and missile removed, and drainage established. Suction was applied to the cavity, which quickly closed and ceased to drain.

A limited resection of the sigmoid colon and closure of the colostomy was carried out two months later and the patient returned to duty.

This case presents several points worthy of emphasis. Wounds of the intestines are usually in pairs, that is, with a point of entrance and one of exit, unless they are tangential. When one discovers a single wound of the colon, particular care should be taken to inspect the mesenteric surface for a second perforation.

Secondly, basic principles of fecal diversion for wounds of the left colon should be adhered to, rather than reliance on antibiotic coverage and single layer closures in the face of peritoneal contamination. The value of suction in aiding the obliteration of "dead space" is also shown in this case. Initially, a Mikulicz exteriorization of the sigmoid colon would have saved this patient considerable time in recovery.

A case of perforation of the small and large bowel is presented with a summary of the complicated postoperative course following ill-advised initial treatment. The recommended procedures are presented.

Rectal Wounds by Gunshot and Impalement

Captain Thomas M. Geer, MC

Wounds of the rectum are relatively uncommon peacetime injuries. The management of such wounds has evolved largely from war experience and there is a tendency for us to forget those principles we do not use commonly. We have had two cases which are worthy of review.



CAPT. GEER

Case 1: A 28-year-old man was admitted with a bullet wound of the perineum. There had been little blood loss and no shock. Temperature was 98.4, pulse 88, and blood pressure 138/92. The wound of entry was at the base of the scrotum, slightly to the right of the midline. There was blood in the rectal ampulla but sigmoidoscopy revealed no perforation.

Exploratory laparotomy on the day of admission revealed no intraperitoneal injury. A sigmoid loop colostomy was performed. Exploration of the tract revealed severe contusion of the rectal wall without actual perforation. Drains were left in the presacral area. The patient's subsequent course was smooth and the colostomy was closed in two weeks.

Case 2: A 19-year-old man was admitted approximately 17 hours after impaling himself on a metal conduit. Five hours after injury he had had a bloody bowel movement. Physical examination revealed temperature of 100° F., pulse 100, and blood pressure 138/108. There was mild abdominal guarding, bowel sounds were normal, and there was blood in the rectal ampulla with a palpable defect in the anterior wall. Sigmoidoscopy revealed a three cm ragged laceration in the rectal wall extending above the prostate.

Abdominal exploration 24 hours after injury revealed no intraperitoneal injury though there was a retroperitoneal hematoma in the region of the bladder and sigmoid colon. A left upper transverse loop colostomy was performed. The rectal wound was not drained externally because the size, location, and direction of the wound allowed for ample internal drainage. Postoperatively, the patient received rectal irrigations with neomycin solution. The colostomy was closed in three weeks.

Injuries to the rectum occur most commonly from missiles, impalement, explosive-type perforation from compressed air or sudden abdominal compression, and laceration from pelvic fractures.

Rectal injury may be easily overlooked, but if the injury is in the intraperitoneal portion of the rectum, diagnosis is easier because there usually are signs of peritoneal irritation. A digital rectal examination is essential. If blood is found then sigmoidoscopy should be done in an attempt to localize the injury and determine its extent. X-ray studies using contrast media are contraindicated because of the danger of extravasation and further contamination.

Once the diagnosis of a rectal wound has been made, there are certain principles to follow in treatment. Since the injured bowel cannot be exteriorized, the fecal stream must be diverted. A number of authors have cautioned against the use of a loop colostomy for this purpose, because it may not accomplish complete diversion of the fecal stream. The danger of this is recognized but we feel that with careful attention to the colostomy and with adequate dressing changes, complete diversion can be maintained with a loop colostomy. In situations where such close attention cannot be given, complete separation with primary surgical maturation of the stomas is recommended.

Another principle of treatment of rectal wounds is drainage of contaminated closed spaces. This is usually accomplished by draining the presacral space. Our second case was unusual, in that this was not required.

Acknowledgment and Thanks

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An intestinal tear may result from a deceptively slight abdominal injury

Traumatic Perforation of Jejunum

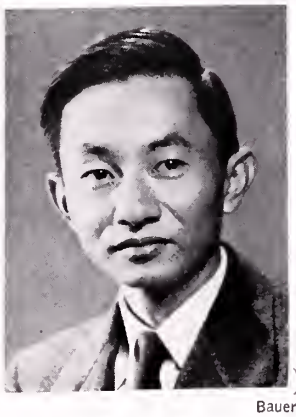
Report of a Case

ROY T. TANOUE, M.D., Honolulu

THE FOLLOWING case shows that even mild physical contact may produce rather startling pathologic injuries which, if left undiagnosed or untreated, could lead to serious sequelae.

Case Report

A seventeen-year-old Japanese boy, while playing "touch" football, was struck in the upper abdomen by an opposing player when both leaped up together to receive a pass. He continued to play, and went to class. However, approximately twenty minutes after the injury, his abdomen became painful and he sought medical attention.



Bauer

DR. TANOUE

On admission to the hospital one and a half hours after the injury, the history revealed the mechanism of the injury. There was no nausea and he vomited for the first time. The vomitus consisted of partially digested food contents. No blood was noted. He appeared to be in some distress, but answered questions coherently and was cooperative.

Temperature was 99.4° F., pulse 90, respirations 16, and blood pressure 110/70. The heart, lungs, extremities, and rectal examinations were negative.

The only findings were confined to the upper abdomen, which seemed tender to palpation, with guarding. Bowel sounds were active. There was no distention. No definite rigidity or rebound tenderness was elicitable.

The laboratory findings included a normal urine, hemoglobin of 12.7 grams, and red count of 4,400,000. The white count was 9,400 with differential of 89 polys and 11 lymphocytes. Plain roentgenograms of the abdomen in the prone and upright positions revealed no significant findings.

In view of the minimal findings, a period of observation was advised, keeping the patient on parenteral fluids only. Three hours after admission, there was a slight drop in the blood pressure, to 90/60. The pulse remained steady. Clinically, the patient appeared more acutely ill than he did upon admission. The physical findings, however, were little changed. A repeat white count showed a slight leucocytosis to 12,500 with polys 88 and lymphocytes 12. Repeat x-rays of the abdomen showed no appreciable change when compared with the original films.

Five hours after admission, the patient appeared to be worse. The abdomen had become rigid, with marked tenderness below the xiphoid area. The bowel sounds were practically gone. In view of the progressive tenderness and developing signs of ileus, an exploratory laparotomy was undertaken.

The patient was taken to the operating room and under a general anesthetic, a midline incision was made to a level two inches below the umbilicus. On entering the peritoneal cavity, a moderate amount of tea colored, slightly brownish fluid was found. This was aspirated. No gross blood was noted. The stomach, duodenum, gallbladder, spleen, kidney areas, and transverse colon were examined. No gross pathology was noted. In order to examine the posterior aspect of the stomach, a rent was made in the transverse mesocolon. No pathology was seen. This artificial rent was closed and the small bowel was next examined. The transverse colon was lifted, and in so doing, it was noted that there was a moderate amount of inflammatory reaction near the ligament of Treitz. Further examination revealed a tangential tear one inch long on the antimesenteric border of the jejunum about one centimeter distal to the ligament of Treitz. The area was carefully lavaged with normal saline and the tear sutured in two layers with interrupted 00000 black silk.

The rest of the abdomen was lavaged with saline and aspirated. A stab wound was made in the left abdomen and a penrose drain placed near the suture line. One gram of streptomycin and 400,000 units of penicillin were placed in the abdominal cavity and the wound closed. One unit of blood was administered during surgery.

Supportive parenteral fluids, Levine suction, and antibiotics were given postoperatively. The Levine tube was removed on the third postoperative day; the drain was removed on the fourth postoperative day. Liquids orally were begun on the third day with progressive increase in nourishment thereafter. The patient was discharged on the seventh postoperative day. Follow-up care revealed good postoperative recovery with no complications.

Comment

This case is presented to show that what could be thought of as a minor injury to the abdomen may in reality be of a more serious nature.

Should a short period of observation reveal progressive deterioration or definite aggravation of symptoms with corresponding findings on physical examination, an exploratory laparotomy should be made without hesitation. A diagnostic abdominal paracentesis or puncture might have given an earlier clue on this case.

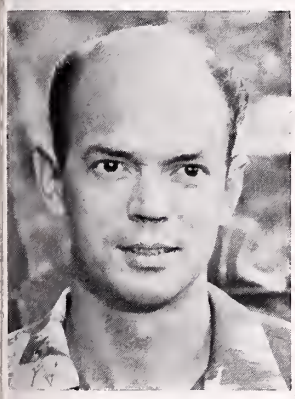
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Traumatic diaphragmatic hernia may be lethal and should be repaired as early as possible

Traumatic Hernia of the Diaphragm And Spontaneous Perforation of the Esophagus

JAMES W. CHERRY, M.D., Honolulu

TRAUMATIC HERNIA of the diaphragm results from massive crushing or warping injuries to the chest. It is frequently undiagnosed because of the confusion attendant upon management of the serious multiple-injury case and the distraction of attention from the injury to the diaphragm and toward the more obvious associated injury. Even in those instances in which the hernia is suspected, the diagnosis may not be made because the x-ray study does not demonstrate the tear in the diaphragm, but only the presence within the thorax of abdominal viscera. This occurrence is sometimes delayed for weeks and even years after the initial injury.



DR. CHERRY

Symptoms of the hernia are related to the obstruction or strangulation of blood supply of the incarcerated viscera. Here, again, a delay of many weeks or months is the rule rather than the exception. The most serious complications associated with traumatic diaphragmatic hernias result from perforation of the hollow viscera into the pleural cavity. This occurs not infrequently when the stomach or colon is herniated, but we were able to find only one other instance in which perforation of the esophagus occurred as a late sequel to traumatic diaphragmatic rupture.

Case Report

A 38-year-old sergeant was admitted to the Irwin Army Hospital approximately 30 minutes following a bizarre highway accident in which he was struck from his motorcycle by a huge tire which came off the axle of a truck approaching him from the opposite direction. On admission, the patient complained of pain in the left arm and chest and pain in the left upper quadrant. Though his injuries were extensive, shock was apparently mild.

Examination revealed an obvious fracture of the left mid-humerus, bony crepitus in the left posterior chest

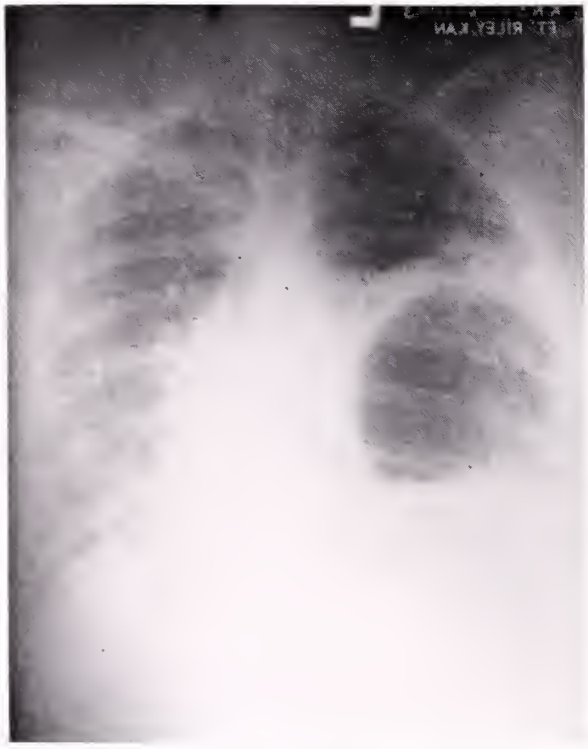


FIG. 1.—*Multiple fractures of the left posterolateral ribs are demonstrated. This finding should always arouse a suspicion of rupture of the diaphragm.*

wall, and moderate guarding of the abdomen with left upper quadrant tenderness. Roentgenograms revealed the fracture of the left humerus and multiple rib fractures posteriorly on the left (Fig. 1). A ruptured spleen was suspected, but the abdominal signs diminished rapidly. The humerus was treated in a partial body cast with abduction and after three and one-half weeks, the patient was discharged from the hospital on convalescent leave.

The patient returned on January 22, 1959, complaining of severe substernal pain and was re-hospitalized with a tentative diagnosis of coronary occlusion. The electrocardiogram was not indicative of myocardial infarction, symptoms rapidly subsided, and the following day the patient was discharged.

Chest x-rays (Fig. 2), examined the following day, suggested herniation of the stomach into the chest. The patient was recalled to the hospital and barium studies (Fig. 3) confirmed the presence of the stomach in the left pleural cavity. At this time the patient felt well and was eating heartily without distress. An elective repair of the herniation was scheduled for February 8, 1959.

The patient was re-admitted to the hospital on February 5 in profound shock, which had begun a few hours before. Chest x-rays were essentially unchanged. Nasogastric suction yielded only a few cubic centimeters of gastric mucus. His condition deteriorated rapidly and within a few minutes after the body cast had been cut away from his chest, cardiac arrest had occurred in the patient's bed. Emergency anterior thoracotomy was done in the fifth interspace on the left. As soon as the pleura was incised, there was a gush of thin seropurulent liquid from the chest cavity which was estimated to exceed



FIG. 2.—*Elevation or rupture of the left diaphragm is indicated by the presence of the stomach high in the chest. Fractures of the ribs can be seen through the gastric air bubble.*



FIG. 3.—*Barium studies confirm the presence of the stomach in the thorax. Though not reproduced well, the original roentgenogram demonstrated the esophagus reentering the chest through the hernia.*

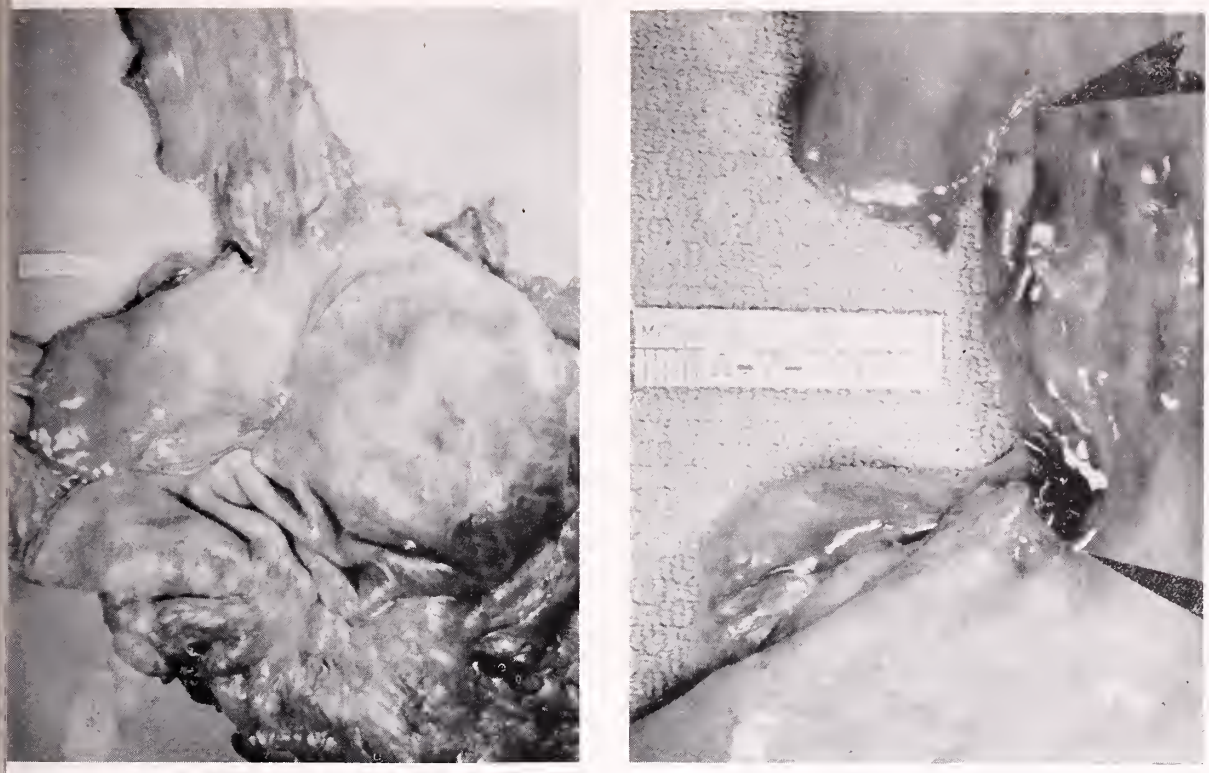


FIG. 4A AND B.—*Autopsy specimen of the stomach and esophagus reveals the erosion of the esophagus from the cardia to an area 5 to 6 cm above the cardia. This is the opened specimen viewed from the mucosal surface. Arrows indicate the margins of the perforation. Note the leathery texture of the stomach, a characteristic noted in stomach long incarcerated in a hernia.*

3,500 cc. Normal sinus rhythm and powerful cardiac beats followed a few vigorous manual compressions of the ventricles. An intratracheal tube was introduced and a closed system of anesthesia and oxygen initiated, and the patient was transferred immediately to the operating room.

There the patient was prepped and draped and the incision was extended. The chest was aspirated. The stomach, which was hugely dilated, had a thick leathery wall and appeared to have suffered some interference with circulation but was obviously viable. The fluid appeared to have been confined to the lesser omental bursa, which had prolapsed upwards into the chest, but thorough inspection failed to reveal any perforation of the stomach. The stomach was replaced in the abdomen and the rent in the diaphragm, which was approximately 9 x 15 cm, was easily repaired with a double row of interrupted silk sutures. Thorough toilet of the pleural cavity and drainage was followed by a closure of the incision in the usual manner. A short left rectus laparotomy incision was then made and several large rubber tissue drains were placed in the lesser omental bursa through the transverse mesocolon, thereby draining the cavity which had contained the tremendous quantity of purulent fluid. At the termination of surgery, the general condition of the patient seemed somewhat improved, but a few hours later, he expired.

Autopsy revealed in addition to the findings described above an oval perforating ulceration of the esophagus about 5 or 6 cm above the cardia (Fig. 4). This portion of the esophagus had been in direct contact with the hard fibrous ring of the hernia.

Comment

The possibility of injury to this patient's diaphragm was considered while managing his multiple injuries initially. However, we were falsely reassured by chest x-rays which did not reveal abdominal viscera within the chest, and therefore failed to follow up our original suspicion that the diaphragm might be injured. In view of the outcome in this instance and in many other reported cases,[1] which would certainly have been avoided had the repair of the hernia been scheduled as a semi-emergency, it seems reasonable to urge that all traumatic hernias be repaired as soon as possible after diagnosis, if other aspects of the patient's general condition permit.

Summary

A case of severe chest injury complicated by traumatic diaphragmatic hernia is reviewed and an unusual delayed complication, esophageal perforation, is described and discussed. It is suggested that every effort be made to find and repair such traumatic hernias as soon as possible after the injury.

1000 Ward Ave.

[1] Chamberlain, M. J., and Ford, J. M.: Diaphragmatic hernia produced by indirect violence, Surg. Clin. N. Am. 33:1505 (Oct.) 1953.
Cooley, J. C., and Rogers, J. C. T.: Traumatic diaphragmatic hernia, A.M.A. Arch. Surg. 79:581 (Oct.) 1959.
Harrington, S. W.: Symposium on abdominal surgery; traumatic diaphragmatic hernia, Surg. Clin. N. Am. 39:961 (Aug.) 1950.
Harrington, S. W.: Various types of diaphragmatic hernia treated surgically, Surg., Gynec. & Obst. 86:735 (June) 1948.
Perry, T., Francis, W. W., and Lonergan, J. C.: Traumatic diaphragmatic hernia, A.M.A. Arch. Surg. 75:763 (Nov.) 1957.
Schneider, C. F.: Traumatic diaphragmatic hernia, Am. J. Surg. 91:290 (Feb.) 1956.

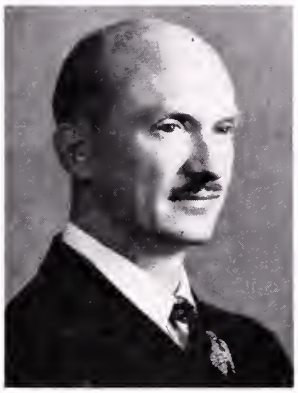
A broken neck may not be apparent in the initial x-rays.

A second "look" may disclose the fracture.

Delayed Traumatic Dislocation of the Cervical Spine

RALPH B. CLOWARD, M.D., Honolulu

IN RECENT YEARS, there has been a great increase in the frequency of acute injuries to the cervical spine. Automobile accidents are responsible for most of these injuries, especially the rear-end-collision variety. In seaside areas, such as Hawaii, we have many neck injuries due to swimming and diving accidents. In the past two years, 17 patients with acute injuries to the cervical spine have come under my care. In a recent report[1] describing a new method of surgical treatment for these injuries, 11 of these cases were reviewed.



Bauer

DR. CLOWARD

Two patients were unusual in that, at the time of injury, roentgenograms of the cervical spine disclosed no alteration in the alignment of the vertebral bodies. Films taken at a later date, however, demonstrated a dislocation of the cervical spine. A detailed report of these two cases seems justified since they demonstrate the importance of careful roentgenographic study of all neck injuries, both at the time of injury and at intervals thereafter, particularly if the patient's symptoms do not improve or increase in severity. The clinical course and treatment employed in these two patients can best be understood if first a brief discussion of diagnostic roentgenographic procedures is given and also a review of the treatment program now being used for these injuries.

Roentgenological Examination

The importance of a careful roentgenographic examination of all patients with neck injuries cannot be over-emphasized. One should never be content with a plain antero-posterior and lateral film of the cervical spine. If a dislocation has occurred as a result of the injury, it will be immediately

[1] Cloward, R. B.: The treatment of fractures and fracture dislocations of the cervical spine by vertebral body fusion. Report of 11 cases. J. Neurosurg. (in press). Read at Harvey Cushing Society meeting April 15, 1960, San Francisco, Calif.

ecognized in the lateral projection. In the absence of this finding, however, one's attention should be focused on the posterior elements of the vertebra. The presence of fissure-fractures in the posterior vertebral arch (pedicles, articular processes and laminae) is extremely difficult to demonstrate radiologically. It is, in fact, almost impossible by ordinary x-ray techniques to exhibit these lesions in the absence of gross displacement. In the lateral projection, for example, the x-rays must penetrate both lateral processes, four articular processes, and two pedicles. Superimposition of these multiple structures makes identification of linear fractures almost impossible. Oblique roentgenograms are more likely to show fracture lines in the articular processes but often these cannot be demonstrated without additional oblique films at different angles. In some cases, the fractures cannot be shown radiologically.

The lack of visual radiographic evidence of demonstrable fracture lines or dislocations will create a false sense of security. This is particularly true in the presence of injury to the spinal cord. Without x-ray evidence of skeletal involvement, injury to structures of the nervous system may be suspected as occurring outside the vertebral axis. Definitive treatment, therefore, may be misdirected.

Discography

A recent and valuable method of study of these injuries is the use of cervical discography.[2] If gross evidence of fracture or dislocation is not present and the patient has neurologic changes referable to the cervical region, an injury to a cervical intervertebral disc should be considered. Extensive laceration of the intervertebral disc at the level of the fracture-dislocation has been demonstrated by discography in each of our cases. It is recommended, therefore, that all patients with neck injuries showing positive neurological signs be studied early by discography, whether a fracture or fracture dislocation is present or not.

Treatment Program

A new operation for lesions of the cervical spine has been routinely used for all cases of fracture and fracture dislocations for the past three years.[3] In this operation the spine is approached from its anterior surface. Open reduction of the dislocation, regardless of its severity, is easily accomplished by skeletal traction (Crutchfield tongs).

After removing the intervertebral disc, a blunt instrument placed in the intervertebral space is used to pry the dislocated vertebra backward, restoring the normal alignment of the spine. A large drill hole, 14 mm in diameter, is made through the intervertebral space. An anterior decompression of the spinal cord and nerve roots is accomplished by removing herniated intervertebral disc fragments. Immediate mechanical fixation and a subsequent fusion of the adjacent vertebral bodies is accomplished by inserting a cylindrical bone dowel in the drill hole.

This operation is recommended in every patient with roentgenographic evidence of fracture or fracture dislocation of the cervical spine as well as those whose discogram shows evidence of disc laceration, with or without involvement of the nervous system. The operative procedure should be carried out as soon after injury as the patient's clinical condition will permit, if possible within the first 24 hours. Skull tongs are routinely inserted at the time of admission to the hospital. Traction is maintained until operation, and usually discontinued immediately thereafter.

In addition to the anterior operation other surgical procedures may be required in some cases. A posterior decompression of the spinal cord or nerve root or both may be necessary if a fracture of the posterior spinal elements (laminae, facet, or pedicle) can be shown to encroach upon these vital structures, impairing their function. A hemilaminectomy and posterior decompression was necessary in one of these cases (Case 2).

Case Reports

Case 1: A 41-year-old Hawaiian man was admitted to St. Francis Hospital on July 9, 1959. The day before admission while attempting to push over a large tree with his bulldozer, he was struck on the back of the head by a branch about six inches in diameter. He was unconscious for about 20 minutes and on regaining consciousness complained of severe pain in his neck and left shoulder.

On admission to the hospital there was a large scalp hematoma in the left occipital region and marked spasm of all neck muscles. Any slight passive movement or palpation was painful. Sensation was intact but slight impairment of pain and temperature sense below the second thoracic level was present. The patient was severely paralyzed. The right deltoid and both triceps were nonfunctional and he was unable to open and close the fingers of either hand. He was able to move the left deltoid, both biceps and muscles of the forearms, but all were extremely weak. There was marked generalized weakness of both lower extremities. He was unable to raise either extended leg off the bed. All tendon reflexes were absent. The Babinski sign was positive bilaterally.

Roentgenograms of the cervical spine and right scapula were obtained on admission, the latter because of severe pain in this location. There was no fracture in the region of the shoulder blade. The cervical spine showed marked narrowing of the intervertebral space at C4-5 but the alignment of the spine was good (Fig. 1B). In the AP projection a transverse diagonal fracture of

[2] Cloward, R. B.: Cervical discography, Technique, indications and use in diagnosis of ruptured cervical discs, Am. J. Roent. Therapy & Nucl. Med. 79:563-574 (Apr.) 1958.

[3] Cloward, R. B.: The anterior approach for removal of ruptured cervical disks, J. Neurosurg. 15:602-617 (Nov.) 1958.

the body of the vertebra extended through the pedicle of C5 (Fig. 1A).

The neurologic diagnosis of severe contusion of the spinal cord at C6-7 level was made. The narrow interspace at the C4-5 level was thought not to be related to the spinal cord damage. Cervical traction was not advised but the patient's head was immobilized with sand bags. He was observed for a period of 20 days during which time the neurological signs neither improved nor became worse. The patient required a Foley catheter. He continued to complain of pain in both upper extremities on movements of his neck.

On July 28, 1959, the cervical spine was re-examined by x-ray. An anterior subluxation of C4 and 5, about 3 mm, had occurred. This dislocation was not present on admission x-rays. In addition there was an increase in the degree of narrowing of the C4-5 intervertebral space (Fig. 1C).

Operation

Crutchfield tongs were applied to the patient in his bed with 20 pounds of weight. The following day the x-ray disclosed a widening of the C4-5 interspace. His pain was considerably relieved by the traction, which was continued for another 48 hours before operation.

Entirely under local anesthesia the anterior surface of the vertebral bodies was exposed through a 4 cm incision. Numerous fragments of torn disc material protruded through the anterior laceration. The dislocation was reduced and the drill hole made. The posterior fibers of annulus appeared to be intact and no herniation of disc fragments into the spinal canal was found. The bone graft was inserted with aid of traction. Skull tongs were then removed at the end of the operation.

The day following surgery the patient was permitted for the first time in the sitting position. Pain in the right shoulder and numbness and tingling of the upper extremities which had been present since injury were greatly improved. He remained in the hospital for two weeks because of urinary tract infection. During this period his strength increased and after ten days he was able to walk without assistance. He was transferred to the Hawaii Rehabilitation Center on August 17, 1959, where he remained as an in-patient for approximately two months.

On December 28, 1959, roentgenograms showed a solid vertebral body fusion (Fig. 1D), but the patient still was markedly paralyzed. Muscles of the left forearm and hand were extremely weak (grade 3) but proximal muscles of the arm and shoulder were only moderately involved. The opposite was present in the right arm, that is, the right hand and forearm were fairly strong, but the upper arm and shoulder muscles showed marked weakness. The most striking finding was atrophy of muscles of both hands. All fingers were flexed at the distal phalangeal joints from which position the patient had difficulty extending the fingers. No single muscle weakness could be demonstrated in the lower extremities but he "rolled" as he walked with a wide, somewhat unstable gait, his arms held loosely at his side. With the disturbing progressive loss of function in the distribution of the ulnar nerve bilaterally, an unrecognized disc lesion below the level of the fracture dislocation was suspected. Accordingly, a cervical discogram was done at the C5-6 level. A rupture and intraspinal herniation of this disc, mostly on the left side, was demonstrated (Fig. 1D).

On January 30, 1960, the C5-6 disc was removed and the joint fused. Postoperatively the patient showed no improvement in the paralysis, but had considerably less neck and shoulder pain.



FIG. 1A.—*Diagonal fracture through body and pedicle C5.*



FIG. 1B.—*Admission x-ray showing no dislocation, only narrow interspace at C4-5.*



FIG. 1C.—*Anterior subluxation developed during 3 weeks in bed (supine) without traction.*



FIG. 1D.—*6 months after C4-5 fusion, discogram demonstrated rupture and herniation of C5-6 disc.*

Comment

This case was obviously poorly handled from the beginning, due to delay in diagnostic and therapeutic procedures. From experience with other patients with fracture-dislocation, the severe pain localized in or referred to the scapula has been found to be due to a disc laceration with or without demonstrable dislocation and is an indication for immediate investigation by discography.[4] Immediate relief of this shoulder pain as well as the neck pain can be achieved by early anterior operation.

This patient also demonstrates the importance of initially investigating by discography the intervertebral discs adjacent to the level of the injury (dislocation). As in this case, a herniated disc lesion at a normal intervertebral space may be missed or go unrecognized. Whether early operation would have made any difference in the patient's recovery is difficult to determine. The extensive and progressive paralysis was probably due to central necrosis of the cervical cord and intramedullary hemorrhage from contusion as described by Schneider *et al.*[5] and Taylor.[6]

Injury to the spine from a heavy blow on the back of the head by acute hyperflexion of the neck consisted of a diagonal linear and probably compression fracture through the body of the fifth cervical vertebra. In addition a fracture of both articular facets, unrecognized at first, accounted for the subsequent dislocation. It is difficult to understand how the anterior subluxation occurred, since during the three weeks from the time of injury until it was recognized, the patient had remained entirely in the supine position. The cause of this delayed dislocation is unexplained.

CASE 2: A 49-year-old Japanese man was admitted to the hospital on August 28, 1959, having been injured when the car in which he was riding was struck broadside by a fast moving truck. The patient was thrown free of the car and against a stone wall. He was unconscious for about one hour, and received multiple lacerations and contusions about the face and neck. He complained of pain on movement of his neck and inability to raise his left arm. The patient was seen in consultation two days after the injury.

There was moderate spasm of the cervical muscles. The neck was guarded against slight movements which were painful in any direction. There was no radiation of pain into the upper extremities. The right arm was essentially normal, but the left arm showed almost total paralysis of the deltoid, biceps and brachial-radialis muscles with marked weakness of the triceps. All forearm and hand muscles were entirely normal. Sensory examination showed marked decrease to all forms of sensa-

[4] Cloward, R. B.: Cervical diskography, a contribution to the etiology and mechanism of neck, shoulder and arm pain, Ann. Surg. 150:1052-1064 (Dec.) 1959.

[5] Schneider, R. C., Cherry, G., and Pantek, H.: The syndrome of acute central cervical spinal cord injury, J. Neurosurg. 11:546-577 (Nov.) 1954.

[6] Taylor, R. R.: The mechanism of injury to the spinal cord in the neck without damage to the vertebral column, J. Bone & Joint Surg. 33B:543-547 (Nov.) 1951.

tion from shoulder to the wrist, mostly on the lateral and posterior aspects, which did not follow a dermatome distribution.

Roentgenograms of his cervical spine disclosed no apparent evidence of fracture or dislocation (Fig. 2A). It was my impression that the patient had probably sustained a contusion or possibly avulsion of the upper cord of the left brachial plexus in the neck. After six days in bed, the muscle spasm had improved considerably, so the patient was permitted to go home.

Three weeks later examination showed essentially the same neurological findings. The patient was unable to flex the left arm. Only a few feeble movements were possible. The deltoid was totally paralyzed. About 20 per cent strength of his triceps was gone, 70 per cent of the supinators, and 10 per cent of the pronators of the forearms. Flexion and extension of the wrist and grip were normal. His neck was still quite rigid, being unable to extend or bend it to the left. The patient was referred to the Rehabilitation Center under the care of Dr. Frederick Shepard, where he received muscle training exercises for the next two months. Function of the paralyzed muscles improved which, although slight, was encouraging. However, the patient complained of pain in his neck, and it was observed that neck movements were limited due to increasing stiffness and pain. A cervical spine x-ray was taken, four months after injury. These films demonstrated a marked anterior subluxation (about 25 per cent) at the C4-5 level (Fig. 2B)! Callus had developed on the anterior surface of the adjacent vertebra. A more careful review was then made of the x-rays taken at the time of injury. These disclosed evidence of a fractured pedicle of C5 on the left side, in addition to a suggestive fracture of the articular facets bilaterally.

The patient was re-admitted to the hospital on January 4, 17 weeks after injury. Crutchfield tongs were inserted into the skull and 30 pounds applied. After four days of traction, x-ray disclosed that there had been no alteration in the position of the dislocated vertebral bodies. On January 8, the patient was operated upon under general intratracheal anesthesia. In the prone position, a unilateral exposure of the C4-5-6 laminae was made and a large Hudson drill hole made over the facet of C4 and 5. A loose fractured fragment of the lower facet was found encroaching upon the nerve root. A complete unilateral posterior decompression of the nerve root was made and the wound closed.

The patient was then turned to the supine position and by the anterior approach the anterior surface of the fractured spine was exposed. Considerable calcified scar tissue was first removed, then the drill hole was made through the interspace. With 50 pounds of traction applied to the Crutchfield tongs and a blunt instrument in the interspace, the anterior dislocation was reduced and normal alignment of the vertebral bodies restored. The bone graft was inserted with the aid of the traction pull.

The patient was kept in traction with five pounds of weight for ten days until the wounds were healed and all muscle spasm in the neck had disappeared. A rapid functional return of the paralyzed muscles in his left arm followed the surgery. When discharged on January 25, he had regained nearly 50 per cent strength of his deltoid and was able to flex his biceps easily against gravity (which he could not do preoperatively).

Postoperative x-rays (Fig. 2C) demonstrated a complete reduction of the dislocation with normal alignment of the spine and a wide posterior decompression of the 5th cervical nerve root (Fig. 2D).



FIG. 2A.—*"Normal" lateral roentgenogram after injury which paralyzed left deltoid and bicep muscles.*



FIG. 2B.—*4 months later "delayed" dislocation of C4-5. Note calcification. (arrow)*



FIG. 2C.—*Postoperative films after unilateral posterior decompression. (arrow)*



FIG. 2D.—*Anterior reduction of dislocation, and interbody fusion.*

Comment

The failure to recognize the fractures of the cervical spine and to correctly interpret the cause of the localized paralysis of the left arm resulted in a delay of over four months before definitive treatment was given the patient. A diagnosis of a nerve root lesion rather than brachial plexus injury could have been made at the time of injury by a *cervical discogram* which would have demonstrated laceration of the disc. The progressive anterior dislocation of the spine must have contributed to the nerve root compression and prevented recovery since posterior decompression and reduction of the dislocation resulted in a rapid and most gratifying improvement in the paralysis even five months after injury.

Summary and Conclusions

Two patients are reported with injury to the cervical spine and serious neurological deficit who demonstrated no evidence of dislocation of the spine at the time of injury, but developed an anterior subluxation at a later date. This was presumed to have resulted from bilateral fractures of the articular processes which were unrecognized in the initial roentgenograms. An impending delayed dislocation can best be recognized at the time of injury by a cervical discogram which will reveal a laceration of the intervertebral disc. If this lesion is demonstrated, immediate operation at the time of injury is advocated.

The operative procedures used in these cases and recommended as the treatment of choice consist of decompression of the spinal cord and nerve roots by an anterior surgical approach followed by vertebral body fusion. If fractures of the posterior spinal elements can be shown to encroach upon the spinal cord or nerve roots, a posterior decompression is also required. These two operative procedures are accomplished simultaneously. Neurological deficit due to extrinsic compression rapidly recovers after surgical decompression (Case 2). Irreversible changes in the spinal cord from contusion and intramedullary hemorrhage will explain recovery failures (Case 1). Hospitalization and convalescence can be considerably shortened by careful roentgenographic studies and early operation to stabilize the fractured spine.

388 Alexander Young Bldg.

A shell fragment tore a man's coronary artery across without penetrating the pericardium!

Serious Cardio-thoracic Trauma Complicated by Cardiac Tamponade

CAPTAIN KENNETH B. BONILLA, MC,
CAPTAIN WILLIAM S. MOSKOVITZ, MC,
CAPTAIN WILLIAM F. QUIGLEY, MC,
COLONEL CARL W. HUGHES, MC, and
COLONEL WARNER F. BOWERS, MC, Honolulu

A 24-year-old Caucasian man was admitted to Tripler U. S. Army Hospital with an open chest wound incurred accidentally one hour prior to admission when a 155 mm howitzer shell burst prematurely at close range. There was a wound of entrance in the left anterior chest wall with both blast injury and low-velocity missile injury destroying the fourth, fifth, and sixth costal cartilages on the left, the lower portion of the sternum and xyphoid process, and a portion of the lower right costal cartilages anteriorly. The missile was visible in the subcutaneous tissue over the lower right anterior chest.



CAPT. BONILLA

The patient was seen initially by a physician at the scene of the accident where an air-tight pressure dressing was applied to the wounds and intravenous dextran started. Shortly after admission to this hospital, the patient had a recorded pulse of 104 per minute and blood pressure of 90/60. The wound in the left chest was a sucking type with an associated pneumothorax on the right and hemothorax bilaterally. There was no clinical evidence of venous engorgement in the head or the upper extremities and the patient was having only mild respiratory difficulty. Chest x-ray revealed a 40 per cent collapse of the right lung and evidence of contusion of both the left mid-lung and the right lower lobe. The cardiac shadow was somewhat enlarged diffusely. No mediastinal emphysema was noted.

From the Department of Surgery, Tripler U. S. Army Hospital.

The patient was prepared for surgical exploration of the chest; however, immediately following endotracheal intubation, the heart sounds became more distant and the pulse weak. Cyanosis was evident in the nailbeds and the mucous membranes. The blood pressure could not be obtained, and the diagnosis of cardiac tamponade was made.

With sterile gloves the chest wound was enlarged and the pericardial sac found to be tensely filled with blood. The pericardium was opened, freeing a considerable amount of old blood and disclosing a laceration of the heart, severing the anterior descending branch of the left coronary artery. Fresh blood now spurted from the right ventricle, and was controlled initially by digital pressure followed by interrupted silk sutures placed through the myocardium.

The patient then was draped for surgery; both chest cavities were explored, the missile was removed from the right thoracic wall, and surgical debridement of devitalized tissues was carried out. A small laceration of the right dome of the diaphragm was noted, beneath which was found a hematoma in the subphrenic space. The diaphragm was opened and a liver laceration was found and debrided and the diaphragm closed. Drainage was established transabdominally with drains brought out through a stab wound in the right upper quadrant of the abdomen. The phrenic nerve on the right had been severed by the missile. Hematoma and contusion about the pericardium were noted as well as severe contusion of the lower lobe of the right lung and the lingula of the left lung. The pericardium was closed loosely and primary closure of the wound was done by sewing the rectus muscles to the severed edge of the sternum and closing the skin over the defect.

A subcutaneous catheter was attached to Steadman pump suction from beneath the primary incision. Bilateral chest tubes, four in number, were placed for



FIG. 1.—*Wound of entrance showing massive chest wall damage and exposure of the pericardium.*



FIG. 2.—*Missile lodged in the soft tissues of the right chest wall in the wound of exit.*



FIG. 3.—*Initial emergency thoracotomy approach through which the pericardiotomy was performed to relieve cardiac tamponade. Note that the pericardium is not lacerated even though the blast ruptured the ventricle and severed a coronary vessel.*

evacuation of blood and to insure expansion of the lungs. A tracheostomy was established, primarily for cleansing of the tracheobronchial tree and secondarily to reduce the dead air space.

Following operation, the patient did extremely well. He was given eight units of whole blood during and immediately after the operation and was treated postoperatively like a patient with an acute myocardial infarction. A tachycardia to 140 per minute on the first postoperative day was controlled by Vesprin, barbiturates, and oxygen. The remainder of the postoperative course was entirely satisfactory, the chest tubes being removed on the third and fourth postoperative days and the subcutaneous catheter on the sixth day. Serial electrocardiograms showed subendocardial ischemia in the anterior septal area of the right ventricle, with gradual improvement over the course of six weeks.

Comment

This case presented a number of interesting features, one of which was the gradual onset of cardiac tamponade secondary to contusion of the intact pericardium with intrapericardial bleeding. The patient's response to evacuation of the pressure within the pericardium was striking; the pulse became palpable and the blood pressure stable immediately following opening of the pericardium and repair of the rupture of the myocardium.

The use of tracheostomy for cleansing the tracheobronchial tree and for improving oxygenation in the damaged respiratory system is a well-accepted surgical principle.

Subcutaneous wound suction was used to advantage in preventing hematoma and in collapsing potential dead space in the subcutaneous tissues and mediastinum. Fortunately the myocardial ischemia secondary to the severing of the terminal portion of the anterior descending branch of the coronary artery was well handled in this young patient and presented no particular problem.



FIG. 4.—*Three dimensional views of the steel missile.*



FIG. 5.—*Postoperative view of the anterior chest wall and tracheostomy scar. There is very little deformity although ribs, cartilages and lower sternum are missing.*



FIG. 6.—*Postoperative lateral view showing satisfactory stabilization of the sternum and rib cage.*

The President's Page



DR. CUSHNIE

The practice of medicine is certainly front page news today. Scientific advances are often found back with the obituaries but socio-medico-economic matters rate headlines. Never before has the senior citizen received so many inches of newspaper space. Occasionally some reporter will mention that these individuals have spiritual needs such as the opportunity to be useful members of the community, but mostly we hear that after a man is sixty-five he is supposed to get off the pay roll and begin to degenerate. This degeneration is expensive and so some of the politicians think that the government should pick up the tab for the senior citizens' medical expenses, which places the burden on the younger groups who are striving to raise and educate their families.

A vast expensive health program highlighted by a compulsory social security program which will take a bigger and bigger bite out of the working man's paycheck is being proposed to finance hospital care, outpatient diagnostic services, and nursing care for every individual over sixty-five who is entitled to social security benefits, regardless of whether his retirement income is in the hundreds of thousands of dollars or only in the hundreds of dollars each year.

Congress is also considering appropriations to provide scholarships to increase the supply of physicians and dentists, grants to bolster community nursing and hospital services, aid to medical and dental schools, and a program to improve the health of children and youths. These and many other matters will make this session particularly interesting to physicians and it behooves all of them to take an active part in legislative matters which affect them and the nation.

Workmen's Compensation fee schedule negotiations are continuing under a new group which includes two appointees from the HMA, Drs. Frederick L. Giles and John J. Lowrey, and two from Honolulu county, Drs. Gilbert C. Freeman and B. Allen Richardson. Progress can be reported in all areas except that no agreement has been reached on the fee for the follow-up office visit. Insurance and business have asked for a survey to determine the "average" fee for these visits. They will not accept the results of the HCMS survey and have expressed the des re to have a survey made ot the charges that go through HMSA. Since the $3.00 fee allowed by HMSA is on an indemnity basis and does not represent the total amount charged by the physician to the patient, the medical representatives did not agree to this proposal. As this goes to press, a survey is being planned which will check the records of commercial insurance carriers to determine the amount that is paid to physicians in Hawaii for a follow-up office visit. Only the records of those doctors who treat Workmen's Compensation cases will be used in obtaining this information.

In the meantime, Representative Cravalho has introduced a bill in the Legislature, HB 19, which would set up a state administered Workmen's Compensation Insurance Fund to underwrite this insurance. It is claimed that premiums would be lowered because the program would be nonprofit. The Insurance Bureau has furnished figures which indicate that less than half of the money paid in premiums by the local firms is paid out in benefits to the employees, the larger portion going to the carriers underwriting the benefits.

The many committees of the HMA have been working hard to finish up their business before the annual meeting. The Bylaws and Parliamentary Committee will present a complete revision of the inadequate bylaws now in effect. The Legislative Committee's work will undoubtedly continue on long past the annual meeting as the current session promises to be one of the longest in legislative history. The public relations set-up with Mr. Hugh Lytle is now functioning and I feel that it will take some time to work out. This is a continuing project and benefits will continue to accrue with each positive aspect of the program. The Arrangements and Scientific Program Committees are completing plans for our 105th Annual Meeting. They have planned an exceptionally fine meeting and I hope that every doctor in every county will be able to attend—except the ones who have to "take care of the store."

Edward Cushnie



attains
sustains
retains

extra
antibiotic
activity

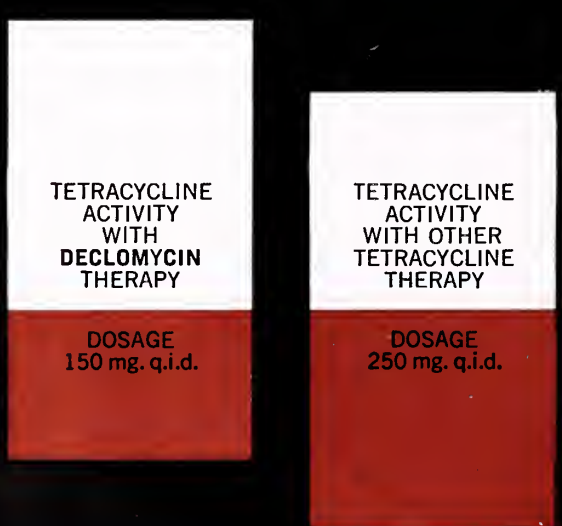
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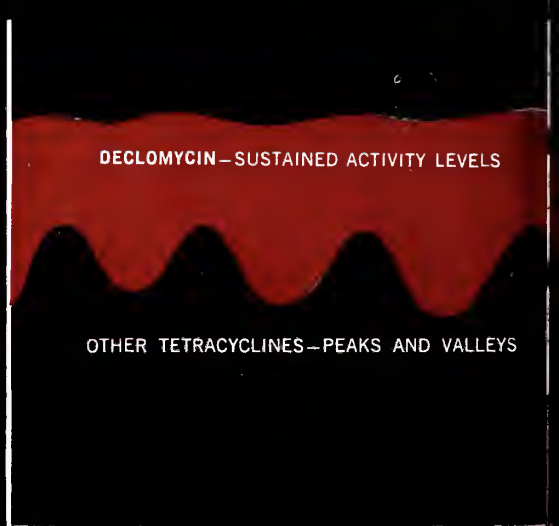
DECLOMYCIN Demethylchlortetracycline attains—usually within two hours—blood levels more than adequate to suppress susceptible pathogens—on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. The average, effective, adult daily dose of other tetracyclines is 1 Gm. With DECLOMYCIN, it is only 600 mg.

sustains activity levels evenly

DECLOMYCIN Demethylchlortetracycline susta through the entire therapeutic course, the high ity levels needed to control the primary infectio to check secondary infection at the original— another—site. This combined action is usually tained without the pronounced hour-to-hour, do dose, peak-and-valley fluctuations which cha terize other tetracyclines.



POSITIVE ANTIBACTERIAL ACTION



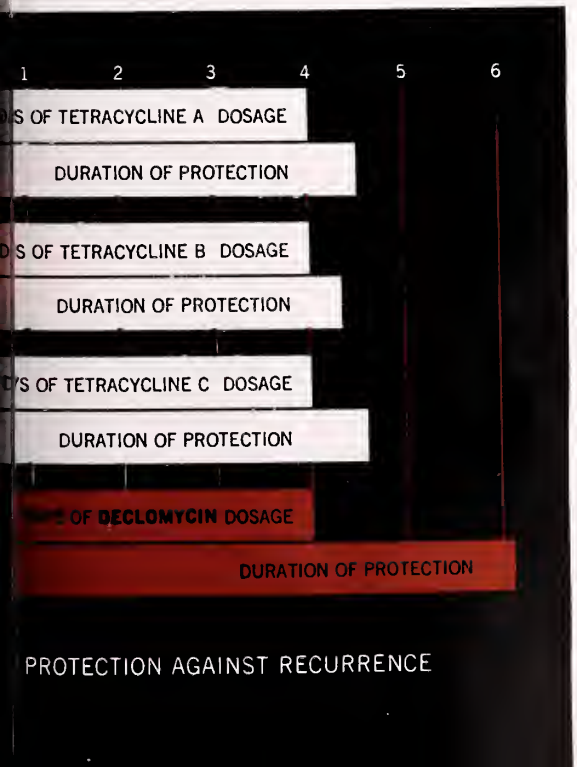
PROTECTION AGAINST PROBLEM PATHOGENS

LOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

tains activity
vels 24-48 hrs.

MYCIN Demethylchlortetracycline retains ac-
evels up to 48 hours after the last dose is
At least a full, extra day of positive action may
confidently expected. The average, daily adult
for the average infection—1 capsule q.i.d.—
same as with other tetracyclines...but **total**
is lower and duration of action is longer.



CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.

Lederle

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Hawaii
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[EDITORIALS]

Some of Our "Angels" Have Flown

This copy of the HAWAII MEDICAL JOURNAL cost a little over $2.00 to produce. If you're a doctor, you paid 67¢ for it; if you're a nurse or a technician, it only cost you 33¢. The difference is made up by revenue from advertising—over $30,000 in total income during 1960.

Most of our advertisements, as you know, are for drugs. In a typical issue, 20 of the 40 advertisers—and 50 of the 75 advertising pages—are promoting a drug.

Their purpose in doing this, of course, is to increase sales; and we are sure that this results from the advertisements. Doctors do read their own state journal. But in buying advertising space, they are getting more than a sound sales-promotion campaign. They are making an investment in postgraduate medical education by lending essential financial support to a state medical journal, and they are making an investment in good will. They are—though it isn't their primary purpose—our "angels."

In our January-February issue for 1960, 25 drug firms bought 71 pages of advertisements. In the same issue for 1961, 17 drug firms bought 33 pages. We are now getting:

NO SUPPORT FROM	LESS SUPPORT FROM	THE SAME SUPPORT FROM	MORE SUPPORT FROM
Ayerst	Abbott	Ames	Mead Johnson
Boyle	Bristol	Burroughs Wellcome	Squibb
Ciba	Eaton	Don Baxter	Tailby-Nason
Pfizer	Lederle	Ethicon	Warren-Teed
Upjohn	Merck, Sharp & Dohme	Lilly	
Wallace	Robins	Parke, Davis	
	Schering	Searle	
	Smith, Kline & French	Winthrop	

Bristol, Robins, Eaton, and Lederle are still supporting us well, and Lederle has been a strong supporter in the past. It is the firms that have dropped out completely that cause us the most serious concern. The net loss of advertising revenue means a deficit of close to $4,000 for the current year, unless we drastically reduce the number of pages of text.

This is a national problem, not a local one; pharmaceutical advertising is vital to all medical publications, and they are all feeling the pinch—especially those publications which, like ours and the other state medical journals, adhere to high standards in regard to products and claims.

We are grateful to America's pharmaceutical firms for their strong support of all state medical journals over the past decades. They have made our publishing projects financially practicable. We believe we have, in return, been an important factor in promoting the sale of their advertised products. And we have—out of conviction, not gratitude—strongly supported their position in such controversial issues as the use of proprietary names, and the "high" cost of modern medicines.

We don't think there's any "fat" that we could easily afford to cut out of the HAWAII MEDICAL JOURNAL. We don't believe we could keep all our subscribers if we charged them $12.00 a year for the magazine. We hope we'll be able to solve this problem in the only other way we can think of: by persuading the drug firms listed above to reconsider their position; to re-enter the fold; and to become once more, as we have called them, our "angels."

The Medical Implication of Oral Polio Vaccines

On the surface it seems wonderful that during ne latter part of 1961 the oral polio vaccine will nally be on the market after having passed strict censing by the U. S. Public Health Services, but nere are many medical considerations that must e studied.

Sabin oral vaccine, like Salk vaccine, still re- uires four doses; vaccines of Type I, III and II re given at intervals of six weeks, followed in ten twelve months by one dose of a trivalent oral accine. This still will entail close following by ne medical profession to insure that correct dos- ges and sequences are followed.

There are possible contraindications to oral vac- ines. It is recommended that oral vaccine be with- eld in persons who have undergone a tonsil- ectomy within a two-week period. Oral vaccine hould be delayed in persons with obvious acute llnesses, except for those with minor respiratory nfections. In Hawaii the optimal time for admin- stration of oral vaccine would probably be from November 1 to March 31 because polio season, as well as the season for other enterovirus infections, begins early in the year. We must also have a legal pinion on such matters as the liability of the manufacturer of the vaccine, of the public health gencies promoting its use, and of the physician upervising the actual administration of the oral vaccine, for incidents attributed properly or by mplication to the vaccine.

The introduction of the oral vaccine into the ommunity would not be best accomplished on the asis of uncoordinated and possibly sporadic vac- ination of individuals by private physicians and ealth agencies. To insure maximum benefit to he community with the greatest safety, oral vaccine should be used on a community-wide basis in a coordinated manner. Each stage of the vaccination program, e.g., feeding of a monovalent type or the final trivalent dose, should be accomplished within a two- to three-week period. Such application not only would achieve more rapidly the desired results of individual immunization and interruption of circulation of wild poliovirus, but also would minimize immunization failures due to interference by contact and acquired infection with heterologous strain of vaccine virus.

The rapid community saturation desired necessitates intensive pre-planning and organization by state and local health departments working with the medical profession and other community agencies. Every local community should be encouraged to organize for this purpose. To be effective a community organization will require the full support of:

1. Official Government Agencies
   The Health Department should lead in the organization, but other official bodies such as the school system, welfare department, the police, etc., will be needed.
2. Professional Organizations
   The county medical societies must play the leading role, but other professional groups such as the pediatricians, obstetricians, hospital administrators, nurses, and social workers will also be needed.
3. Voluntary Agencies
   The National Foundation has a logical primary interest, but the active support of many other citizen groups and lay organizations will be essential to success.

MASATO HASEGAWA, M.D.

Eosinophilic Meningitis

Beginning in March 1958 many hundreds of cases of an unusual type of meningitis of unknown etiology occurred on the island of Tahiti in French Polynesia. Since the most characteristic feature of this meningitis was a pleocytosis consisting in large part of eosinophils, the disease was called eosinophilic meningitis.

The most characteristic clinical features of the disease were headache, stiffness of the neck and back, and paresthesias of different types. Approximately five percent of cases had a facial paralysis of the peripheral type. The duration of illness varied from several days to several months, and recurrences were common. No deaths occurred.

More than one-half of the cases had a pleocytosis of 500 or more cells per mm^3 of cerebrospinal fluid, and in 85 percent eosinophils accounted for more than one-fourth of the pleocytosis.

Examinations of spinal fluid, blood, and feces were negative for the presence of viruses, pathogenic bacteria, and fungi. No helminthic parasites

were found other than those commonly infesting the inhabitants of the area. Serologic examination of convalescent sera with antigens for a number of arthropod-borne viruses, enteroviruses, Leptospira, and other microbial agents gave no indication of the etiologic agent.

The disease occurred primarily in adults and affected both sexes equally. Persons of Polynesian or part-Polynesian origin appeared to have a higher attack rate than Europeans or Chinese.

There was no sharp seasonal distribution and cases occurred in every month of the year.

The geographic distribution of cases correspond roughly to the distribution of the population, and there was no definite evidence of a higher attack rate in either rural or urban areas.

The disease did not appear to be transmitted from person to person or from one geographic area to another. There was an aggregation of cases by household which suggested the effect of a common exposure rather than person-to-person transmission.

The incubation period was estimated to be between two and four weeks.

Although the etiology of eosinophilic meningitis was not determined, the sum of the clinical and epidemiologic evidence suggested the hypothesis that the disease was caused by a helminthic parasite of the skipjack tuna or oceanic bonito (Katsuwonus pelamis) and possibly other pelagic fish which are commonly eaten raw in the area.

Dr. Leon Rosen of the National Institute of Allergy and Infectious Diseases, National Institutes of Health, Public Health Service, Bethesda, has directed an extensive investigation of this disease in Tahiti. Dr. Rosen was recently in Hawaii enroute to Tahiti to conclude his investigations. Dr. Rosen is extremely interested in learning of any cases of eosinophilic meningitis that have occurred in Hawaii or may occur in the future. Anyone knowing of such cases or desiring more detailed information on the disease, please contact Dr. Gordon D. Wallace, Hawaii State Department of Health, Honolulu.

Social Security Medicine

The provision of medical care to older persons through Social Security—the Forand approach—is being vigorously promoted for what we hope is a variety of reasons—from President Kennedy's belief that it is good politics to Wilbur Cohen's confidence that it is a good solid foot-in-the-door for the coming Welfare State.

We agree with the official A.M.A. position: that it is the wrong approach to the problem, and the Kerr-Mills Law is the right one, because:

1. The Forand approach is **unnecessary:** the Kerr-Mills Law will provide all needed Federal assistance for whatever services each state wishes to provide!

2. No Federal bureaucracy could help surrounding the provision of medical care with **endless red tape and restrictions;** it's hard enough to avoid this at the state level.

3. **Private health insurance would be stifled** for this age group by the Forand approach.

4. The Forand, Social Security solution would be **staggeringly expensive,** and the expense would mount higher as time went on.

5. The Social Security approach would cover thousands who **do not need** such assistance and should not get it, and would **fail to cover** tens of thousands who do need it; the Kerr-Mills Law would provide medical care and hospitalization where—and wherever—it is needed, on the basis of local determinations.

6. **Compulsory national health insurance** would be just an amendment away, if the Social Security approach were adopted; all it would take would be a lowering of the age limit and a little extension of benefits.

Thirty states, as of last month, were ready to implement the Kerr-Mills Law. Four states had their programs going: Kentucky, Massachusetts, Michigan and Oklahoma. Hawaii should be ready to operate by the time this appears in print.

If it isn't too late, please write to Senators Long and Fong, and to Representative Inouye, and urge them to give the Kerr-Mills Law a chance to work rather than pile another few per cent onto the Social Security tax by creating a Federal medical bureaucracy to give us something we don't need and don't want. Write a letter—today!

This is What's New!

The treatment of **inoperable bronchogenic arcinoma** is reported from New York. Some 500 atients with the disease received various drugs nd the response to therapy evaluated. **Nitrogen nustard** proved the best of the lot while cortisone ot only failed to produce improvement but instead caused a shortening of survival rate. Progesterone proved almost as bad as cortisone. (*Am. J. Med.* [Dec.] 1960.)

* * *

The demyelinizing syndromes—including multiple sclerosis—have been regarded by some as being allergic in nature. A German worker reviews his investigative results along with those of others and concludes that some type of **immunopathic process** takes place in **human demyelinizing encephalomyelitis.** (*World Neurology* [Dec.] 1960.)

* * *

Unilateral kidney disease may result in **curable hypertension.** The problem is how to diagnose it. A Baltimore group used four different tests to answer this question with the following results:

1. Catheterizing both ureters and measuring differences in salt and water excretion. Test unsatisfactory in 45 per cent of patients.

2. Translumbar renal angiography. Results: one death, one paraplegia and at least one false positive test.

3. TEAC pressor test—unreliable.

4. **Radioiodine renogram.** "No patient (studied to date) with a normal radioactive renogram has been found to have renal hypertension." Two false positives? Conclusion? **Screen** hypertensive patients for unilateral renal disease with **radiorenogram**—cautious use of **additional** procedures in those **positive** for unilateral disease. (*Ann. Int. Med.* [Nov.] 1960.)

* * *

Hyperparathyroidism, classically a disease of stones, bones, and abdominal groans, must also be considered in patients presenting **vague symptomatology,** such as fatigue, lassitude, muscular weakness, and poor appetite. These symptoms, attributable to **hypercalcemia,** occur in the over 15 per cent of patients who lack renal stones and bone disease. (*Brit. Med. J.* [Jan. 28] 1961.)

An English physician speaks out strongly and clearly for continuation of the **personal medical advisor** who, were he to disappear, "would not bring forth an outcry from the public or Ministry of Health," and even though "the fragmentation of medicine, the adulation of teamwork, the curious belief that uniformity is somehow identical with justice, the unquestionable fact that he is, as they say, 'uneconomic'—all these militate against him. His chances seem poor and yet if he goes the sum of human unhappiness, great enough already, will be greater." (*The Lancet* [Nov. 26] 1960.)

* * *

Phenylketonuria, a rare gene-determined form of mental deficiency, is treatable. **Untreated** infants with the tainted gene are normal at birth, but if untreated, progress on to develop **mental deficiency, epilepsy, dermatitis,** and a peculiar **body odor.** If treatment with a **low phenylalanine diet** is started within the first few months of life, normal mental development always occurs. If treatment is delayed until the child is five years old, there is little improvement. Diagnosis? **$FeCl_3$ test on urine** of infants suspected of having the genetic defect. (*Deutsche Med. Wchnschr.* [Jan. 6] 1961.)

* * *

Biochemists in France have recently found that **aspirin** is strongly **anticomplementary,** cortisone slightly less so and sodium salicylate not at all. The test used was a complement-dependent hemolytic reaction *in vitro.* (If this is true, aspirin may be **more beneficial than cortisone** in those hemolytic and related diseases in humans where complement is involved.) (*Nature* [Jan. 14] 1961.)

* * *

New **anti-cancer drugs** continue to appear. **Vincaleukoblastine,** an alkaloid extracted from the periwinkle herb, has been rather effective in experimental animal cancer but thus far appears too toxic for large scale use in humans. **Uracil-mustard,** a new oral nitrogen mustard, has held up well in the clinical trials. Two investigators have reported it to be the most effective oral mustard thus far. It probably will be commercially available soon. (*The Lancet* [Feb. 4] 1961.)

FRED I. GILBERT, JR., M.D.



Long ago men realized that for a tree to withstand the storm, its roots must reach deep as its branches spread high.

STRENGTH...

The strength of HMSA is the combined strength of the Physicians, Hospitals and over 40 per cent of Hawaii's people who OWN and ARE HMSA. This combination working in mutual interdependence has sustained each other as do root and branch. In the words of John W. Castellucci, Executive Vice President of National Blue Shield: "Although Hawaii is our newest State, its citizens, physicians and hospitals have joined together to create in HMSA a medical care prepayment plan second to none in the nation. This achievement should serve to remove all doubt of the capability of private initiative to meet the challenge of providing our people with a workable, voluntary means of financing the cost of health care."

HAWAII MEDICAL SERVICE ASSOCIATION

A Non-Profit Community Service Organization for Prepaid Health Care

Member, Western Conference of Prepaid Medical Service Plans

HMSA

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Infant Death Case Study No. 11

An 8 lb., 2 oz. boy was born of a healthy 18-year-old Japanese primigravida whose STS was negative and who was blood type A, Rh positive. Labor had begun at 4:30 P.M., and after an hour, at the hospital, membranes were intact, presentation was vertex, ROT, and fetal heart was strong at 156. Three hours later the mother's temperature had risen to 100.6° F. and she was given 2 cc of Combiotic, after which temperature remained normal.

After 25 hours of uneventful labor, with fetal heart rate remaining between 150 and 160, membranes were ruptured mechanically and 75 mg Demerol and 25 mg Phenergan were given. Three hours later she was given 50 mg Demerol and 25 mg Phenergan and 1/200 gr scopolamine. Two hours later, under general anesthesia, she was delivered of a viable baby from an ROA position over a left mediolateral episiotomy. The attending physician used elective low forceps.

The infant, described as "very sleepy, color good," cried vigorously when given 0.2 mgm Nalline IM, though he was said to have required "active resuscitation" (method not stated). At the nursery he was described as "good." A physician examining him in the morning noted a forceps mark on the left cheek and a "fair cry." Because of resuscitation, penicillin was begun in the nursery; streptomycin and chloromycetin (60 mg q 12 hours) were added at 12 hours of age; only three doses of each were given.

Examination again at 36 hours of age showed "cry is still subdued." Activity was normal, however, color fair, and an intact Moro reflex was observed. Six hours later he looked "dusky" and oxygen, 5-6 liters per minute, was started by Isolette. An hour later he looked no better and a chest x-ray was ordered. The physician saw him an hour later and noted that he was dusky and in moderate respiratory distress. Subdural taps disclosed only 1 and 2 cc of pink-tinged fluid on the right and left sides respectively. Two hours later the baby looked better, with less grunting and improved color.

Progressive swelling around the tap sites began an hour later; at 47 hours of age respirations were 108 and labored; respiratory distress increased and respirations ceased at 52 hours of age. Autopsy disclosed subdural and subarachnoid hemorrhage, interstitial pneumonitis, and pulmonary congestion, hemorrhage, and partial atelectasis.

Discussion: From the clinical course, this baby's death was felt to be due to respiratory insufficiency. However, the role of the subdural hematoma could not be overlooked and was the subject of considerable discussion within the committee. Death due to subdural hematoma results from compression of the brain stem against the bony foramen magnum and requires a large amount of blood to increase the intracranial pressure to lethal levels. This is in contrast to the small amounts of blood which may be lethal in the subarachnoid space. Thus, while the intracranial hemorrhage noted on autopsy and described in detail by the pathologist's report could have been contributory, the infant's death was considered most likely the result of the interstitial pneumonitis. The presence of fever in the mother 26 hours prior to delivery would suggest that this pneumonia was antenatal in onset and there was some evidence that the baby was in distress before delivery. That this pneumonia was most likely viral was also suggested by the pathologist's report.

Although it was not contributory to the infant's death, the mother was considered to be over medicated with sedation plus anesthesia, and the baby might have been spared the additional manipulation of resuscitation had the mother been given Nalline before delivery.

Classification: Obstetric-pediatric death, unclassifiable as to preventability because of lack of precise knowledge as to the primary cause of death.

One of a series of case reports prepared by the Advisory Committee to the Bureau of Maternal and Child Health to illustrate the type of study made in the instance of an infant or maternal death in Hawaii.

In Memoriam--Doctors of Hawaii--XXXI

This is the thirty-first installment of In Memoriam —Doctors of Hawaii.

Harry Bryant Cooper

Harry Bryant Cooper was born October 5, 1873, at Carrollton, Missouri, the son of Dr. John C. and Lucy (Harris) Cooper.

His education was received at the University of Missouri and the Kansas City Medical College, which granted him his M.D. degree in 1899. Later Dr. Cooper did special work in dermatology at Rush Medical College and attended the Ochsner Clinics and the Washington Medical School at St. Louis for courses in pediatrics.



DR. COOPER

In June, 1904, when Dr. Charles B. Cooper of Honolulu was visiting his uncle, Dr. John Cooper, in Carrollton, he asked Dr. Harry if he would be interested in coming to Honolulu to practice. This suggestion met with Dr. Harry's approval, and in January, 1905, he arrived on Kauai to become plantation physician for the Koloa Sugar Plantation. After two and a half years on Kauai, Dr. Cooper came to the Honolulu Plantation at Aiea where he served from 1907 to 1928. During this period he was physician for Palama Settlement from 1919 to 1923 and from 1922 to 1930 he also served Waianae Plantation.

Dr. Cooper married Miss Florence Thomas Cooper at Carrollton, Missouri, on December 30, 1903. Four children were born to the doctor and his wife: Dr. John William, Harry Bryant, Jr., Elizabeth (Mrs. Calvin Terwilliger) and Lawrence Thomas, who died at the age of two.

In 1930 Dr. Cooper retired, but from time to time during the next twelve years he took over the practice of physicians away on vacation. Covering for his colleagues, he practiced at Waipahu Plantation, Waimano Home for three months in 1932, Waialua Plantation for a month in 1934, Lanai Pineapple Company for three months in 1934, Kahuku Plantation for a month in 1936, Ewa Plantation for a month in 1940, and at the Kaneohe Territorial Hospital at various times between 1937 and 1942.

During World War I, Dr. Cooper was the examining physician for Draft Board No. 2. During World War II, he performed the same service as well as being on the staff at Emergency Hospital.

At the time of the first World War, the doctor learned to operate a knitting machine and made socks for the Red Cross Unit at Aiea. He knitted 200 pairs of tops to heels, which were then completed by the women of the Unit. A crippling spinal condition confined Dr. Cooper to a wheel chair in 1948, so he renewed his interest in weaving. Using a small hand loom, he made hundreds of blankets, scarves, afghans, and baby jackets which h gave to his friends.

In 1955 Dr. and Mrs. Cooper moved to Mill Valley California, and in December, 1958, they celebrated thei 55th wedding anniversary.

On January 16, 1959, Dr. Cooper died in Mill Valle at the age of 86.

Dr. Cooper was a member of the Hawaiian Medica Association, the Honolulu Medical Society, the Americai Medical Association, the Honolulu Elks Club, and th First Christian Church of Honolulu.

Young Ernest Colville

Young Ernest Colville was born in Washington, Ten nessee, on August 13, 1877. He was the son of Richar W. and Mary Louisa (Paine) Colville.

His early education was received at Chattanooga Higl School from which he graduated in 1894. He received a B.S. from Chattanooga Normal College in 1898. H served 14 months in the Army during the Spanish American War. Then he attended the University o Tennessee for one year in 1899. In 1903 he was grante his M.D. from Chattanooga Medical College, and i 1904 he was granted a second M.D. from Tulane Uni versity. Dr. Colville was resident physician at Barones Erlanger Hospital from 1904 to 1905.

On January 10, 1905, Dr. Colville was married t Gladys Agnes Brause at Chattanooga.

Dr. Colville began his practice at Middlesborough Kentucky, in 1905. In 1907 he moved to Oklahoma Cit where he continued his practice and served as editor o the Oklahoma State Medical Journal.

Coming to the Islands in 1909, he settled in Hilo.

He was commissioned a captain in the Medical Re serve Corps in September, 1917, and called to activ duty on January 12, 1918. He was promoted to majo on May 7, 1918, and honorably discharged on Septembe 12, 1920.

After the death of his first wife, Dr. Colville marrie Mrs. Paula Rosalie Steele at Tucson, Arizona, on Apri 25, 1919. He resumed his practice at Hilo in November 1920. He and his wife were both active in Democrati politics, and Dr. Colville was a member of the Demo cratic Territorial Central Committee.

Dr. Colville died January 31, 1935 at Hilo at the ag of 58. He was a member of the American Legion, F. & A. M., Knights of Pythias, and I. O. O. Lodges. He wa a member of the Phi Chi fraternity.

Tsuneo Yoshimura

Tsuneo Yoshimura was born in Sakashita mura, En gun, Gifu Prefecture, Japan, in 1878.

He was graduated from the Aichi Medical School a Nagoya in 1901 and became an army doctor.

Coming to Hawaii in 1908, he began his practice a 1429-B Fort Street in Honolulu. He was the first of th Yoshimura doctors to come to the Islands. His nephews Eiji and Ikuo, followed him and practiced in Hilo Hawaii.

After some 16 years of practice in Honolulu, Dr Yoshimura returned to Japan where he died on Septem ber 12, 1926, in Gifu.

Book Reviews

umors of Childhood

y Harold W. Dargeon, M.D., 476 pp., $20.00, Paul B. Hoeber, Inc., 1960.

This work is an exhaustive and detailed enumeration nd discussion of all forms of tumors encountered in hildhood, both benign and malignant. It is based on wenty-five years of experience involving over 6,000 hildren at Memorial Hospital for Cancer and Allied)iseases in New York. This book is particularly valuble as a reference work for pediatricians and surgeons ealing with pediatric problems.

DONALD C. MARSHALL, M.D.

★Treatment of Cancer and Allied Diseases, 2nd Ed., Vol. 1, Principles of Treatment

3y George T. Pack, M.D., F.A.C.S., Irving M. Ariel, M.D., F.A.C.S., 646 pp., $22.50, Paul B. Hoeber, Inc., 1959.

When the rewriting of the original three-volume work s complete it will consist of nine volumes, the first being oncerned with the principles of treatment and each of he other eight covering one or more anatomical regions. mphasis will be on time-proven methods and where ontradictory evidence exists, the editors attempt to offer ne adequate perspective by including discussions pro- ounding both therapeutic ideologies.

The first volume covers all phases of tumor treatent and deals in considerable detail with the many undamental principles involved. It is divided into ten eneral sections: (1) Organization (cancer prevention, letection, and tumor clinics, home care). (2) Diagnosis nd pathology (microscopic grading, biopsy, cytology, issue culture). (3) Surgery (general principles of re- and postoperative management, electrosurgery, and pecial vascular problems related to neoplasms. (4) Irradiation (radiation physics, tumor radiosensitivity, and iologic effects of ionizing radiation). (5) Clinical aplication of roentgen rays (low, medium, and supervoltage x-ray, rotational therapy, and Betatron applicaion). (6) Clinical application of radioactive isotopes. 7) Prevention and treatment of radiation reactions. (9) Hormone therapy, chemotherapy, and general care of he cancer patient. (10) Reporting end results of cancer reatment.

Although some chapters, especially those dealing with onizing radiation, are quite technical, nevertheless to the asual reader they will still afford good orientation.

GROVER H. BATTEN, M.D.

★Treatment of Cancer and Allied Diseases, 2nd Ed., Vol. 2, The Nervous System

3y George T. Pack, M.D., F.A.C.S., Irving M. Ariel, M.D., F.A.C.S., 316 pp., $15.00, Paul B. Hoeber, Inc., 1959.

This volume represents a compilation of the opinions of eminent authorities in the fields of neurologic surgery and radiation therapy and covers chapters on diagnosis, anesthesia, irradiation therapy, and surgery, both in general and as related to individual problems. Palliative efforts as well as those for cure are equally emphasized.

GROVER H. BATTEN, M.D.

★ Highly recommended.

★Treatment of Cancer and Allied Diseases, 2nd Ed., Vol. 3, Head and Neck

By Seventy Authors, Edited by George T. Pack, M.D., F.A.C.S., Irving M. Ariel, M.D., F.A.C.S., $30.00, 781 pp., Paul B Hoeber, Inc., 1959.

This volume maintains the high standards of the preceding two volumes. In it are presented all presently accepted therapeutic methods. Again the authors have been drawn from treatment centers in many parts of the world. Their presentations are excellent.

In summary, this reviewer finds both the contents and physical qualities of these first three volumes of superior quality and recommends them without qualification. He is anxiously looking forward to the arrival of the next six volumes.

GROVER H. BATTEN, M.D.

The Preparation of Medical Literature

By Louise Montgomery Cross, M.A., 451 pp., $10.00, J. B. Lippincott Co., 1960.

A doctor writing his first papers for publication should read this book, and would do well to own it. It is a primer of writing, and it is aimed at physicians, especially those without experience in writing.

There are four chapters on planning, four on gathering material, three on writing, eleven on style, nine on illustration, and nine on editing. Those on illustration are particularly detailed and practical.

The Preface notwithstanding, this book is not unique. It does go somewhat beyond Fishbein's, Davidson's, and Hewitt's handbooks of writing in the fields of illustration and editing, and in advice on preparation of books; but these exceptions aside, it is not an improvement on them.

HARRY L. ARNOLD, JR., M.D.

Meaning and Methods of Diagnosis in Clinical Psychiatry

By Thomas A. Loftus, M.D., 169 pp., $5.00, Lea & Febiger, 1960.

"This book . . . should sharpen the diagnostic acumen of the psychiatric resident, and be most helpful to the general practitioner who is seeking an understanding of the protean symptomatology observed in a large segment of his daily practice."

ROBERT A. MATTHEWS, M.D.

Also Received

Projective Techniques with Children

Edited by Albert I. Rabin, Ph.D., and Mary R. Haworth, Ph.D., 392 pp., $11.75, Grune & Stratton, 1960.

Twenty-two contributing authors, almost all Ph.D.'s (one an M.D.) have much of interest to say about psychometric tests in children.

★Bedside Manner

By I. Snapper, M.D., 592 pp., $14.50, Grune & Stratton, Inc., 1960.

Concise and thoughtful discussions of bedside diagnosis of almost all nonsurgical diseases by a master

(Continued on page 394)

Notes and News

Local Doctors in Print

Drs. George Henry and **Robert Hunter** are co-authors of an article entitled "Hysterosalpingography with Water Soluble Medium (Salpix)" in the November, 1960, issue of the *American Journal of Roentgenology Radium Therapy and Nuclear Medicine*. **Drs. Grant Stemmermann** and **Noboru Nakasone** collaborated on "Strongyloides Stercoralis Infestation" which appears in the November 5, 1960, issue of the *Journal of the American Medical Association*. **Dr. Stemmermann** has a second article in the *American Journal of Clinical Pathology*, "Adenocarcinoma of the Intrahepatic Biliary Tree Following Thorotrast."

Dr. Philip M. Corboy has an article on the June, 1960, issue of *Guildcraft* on "A Chinese Japanese Projecto-chart Slide."

Names in the News

Kuakini Hospital Directors' annual New Year's cocktail party received rave notices in the local papers. Among the dignitaries were Governor and Mrs. Quinn and Mayor and Mrs. Blaisdell. The evening paper's editorial of January 19, 1961, on fifteen years of socialized medicine in Great Britain, was ably countered by the Honolulu County Medical Society's president, **Dr. A. S. Hartwell. Dr. Ed Cushnie,** Hawaii Medical Association president, did the same to counter the morning paper's editorial of January 3, 1961, on the care-of-the-elderly program. **Dr. Claude Caver** is advocating the adoption of the 23rd Amendment (calling for economic freedom) to end personal income taxes. Great if it works!!! But what a dreamer!!! **Dr. Linus Pauling** will teach courses in personality at the YMCA—we need that in the profession.

TELL NELSON, M.D.
1899-1960

Tell Nelson was stricken suddenly and died in a few hours early in the morning of November 18, 1960. He had been in failing health for several years, at times unable to work at all and most of the time carrying on a limited practice; however, a hard fall while exercising his beloved poodles was apparently responsible for his demise.

Born in New York City in 1899, he received his bachelor's degree from the University of Chicago, his master's from the University of Illinois, and his M.D. from Rush Medical College (1923). He interned at Evanston, then entered practice and continued in practice until his death except for time spent in the Army (January 1941, to November 1946; Colonel, MC, AUS; stationed in Hawaii).

In lieu of residency, he did research and teaching in allergy, and was a member of the attending medical staff at the University of Chicago, 1925 to 1929, and the University of Illinois, 1928 to 1941.

His societies included American Academy of Allergy (fellow and charter member), American College of Allergists (fellow and charter member), Chicago Society of Allergists (president, 1938), Chicago Institute of Medicine (fellow), American Therapeutic Society, Sigma Xi, American Association of Immunologists, A.A.A.S., Association of Military Surgeons, Honolulu County Medical Society, Hawaii Medical Association, and AMA (fellow).

According to information in his personal files, he refused offered certification by the Board of Internal Medicine as a charter member because he believed there should be a separate board of allergy.

In one capacity or another, mostly as consultant, he was on the staff of all the Honolulu hospitals including Leahi, and Kaneohe State Hospital. He was a consultant to the Department of Health's Child Health and Crippled Children bureaus.

His publications were mainly in the fields of airborne allergens and of immunology as related to allergy, but he was proudest of his research in kidney growth.

After World War II he remained in Hawaii and became the first physician here to practice allergy exclusively. He studied local allergens and found them allergenically not identical with mainland examples of their species. Consequently he collected his own supplies on field trips and prepared his own extracts. In the course of collecting pollens on the Big Island, he averred that a tree branch broke and dropped him into an earthquake crack near Kilauea, and that the rangers whom he was accompanying had to haul him out. The crack was large enough to have engulfed a man of less than Tell's generous amplitude. He left an office crammed with such raw materials as jars of termite wings and mold cultures in variety.

In 1948 he married Teresa Ann Dickie, who survives him. He is also survived by a stepson and by two daughters of a former marriage who live on the mainland.

Tell Nelson made a notable contribution to the care of the allergically handicapped in Hawaii. Physicians on all the islands depended on him for diagnostic studies and for direction in the administration of the custom-tailored extracts which he made and sent them. He also made a contribution to good fellowship. A bit gruff when not quite at ease with strangers, on acquaintance he was a rich mine of conviviality, anecdotes, and ribaldry. He treasured his many friendships, and had a larger supply of kindness in his heart than is granted to many men.

LOUISE S. CHILDS, M.D.

r. Richard You was a recipient of an invitation to President Kennedy's inaugural, which he attended. **Dr. Leaert Fernandez** received well deserved recognition for his fforts on behalf of Juan Rosario, seventeen-year-old Guamanian, who had suffered severe scars from burns. **r. John Chalmers** was mentioned briefly by a local olumnist as briskly walking along Union Square in San rancisco. Medical Examiner **Dr. Alvin Majoska's** testiony in a recent accidental death case made headlines nd good reading recently. **Dr. Mary Glover,** on a mision with HOPE, and **Dr. Charles Judd,** recent Japan isitor, continue to contribute material on their experinces in the Orient. **Dr. Peter Kim** of Kauai reports major ntributions to the development of the new Work herapy Unit of the Mahelona Hospital. **Dr. Ira Hiscock,** isiting Carnegie professor of Public Health, was honred by the Oahu Health Council at a testimonial luncheon. Conspicuously present were HMA President, **Ed ushnie,** and four past presidents—**F. J. Pinkerton, Nils . Larsen, Harry L. Arnold, Jr.,** and **Toru Nishigaya.**

The **Pacific Medical Associates** are in print again. This me a suit for 1.7 million against the Kaiser Health Foundation . . . more headaches for the people at Ala Moana when a patient filed suit for $200,000 against two of their staff doctors. In *Medical Economics* for January 30 is the story of the original blowup.

Dr. Sumner Price, until recently administrator at Queen's, was appointed Chief of the State Health Department's Office of Hospital and Medical Facilities. Eye men—**Moffat, Kimata, O. D. Pinkerton,** and **Herbert Pang**—made fine presentations in HMA's "For Health's Sake"—a KONA-TV program on the Eye. **Dr. P. Howard Liljestrand,** President of the Hawaii Hospital Association, announced the appointment of a new executive director, the first to hold such office, Mr. W. Glenn Ebersole. **Dr. C. C. McCorriston's** son William made headlines off Sunset Beach. New administrator for Children's Hospital is **Mr. Philip Pharazy,** who was formerly of Redwood City, California. **Dr. Fred K. Lam, Sr.,** as acting chairman of the University of Hawaii's Board of Regents, recently was hot news regarding negotiations over professional baseball in Hawaii. **Mr. R. M. Kennedy** (HCMS executive secretary) and **Dr. Gilbert Freeman**

(Continued on page 380)

EICHI MASUNAGA, M.D.
1904-1960

Dr. Eichi Masunaga was born on November 1, 1904 in Kalihiwai, Kauai. His parents were Iwajiro and Toyo Masunaga. He attended the Royal School and McKinley High School in Honolulu and graduated from the University of Hawaii with a major in Biological Sciences. Before entering medical school, he worked as a physiologist for the Hawaiian Pineapple Association and as a laboratory technician and research assistant for the United States Public Health Service. He also worked at the Kalihi Receiving Station. He graduated from Washington University Medical School at St. Louis, Missouri, in 1943 and took his internship at the St. Louis County Hospital. Arriving in Honolulu, he was a resident physician at Kuakini Hospital until November, 1944, when he took over Dr. David Betsui's practice in Hanapepe.

Doctor Masunaga was pathologist for the G. N. Wilcox Memorial Hospital for a number of years before his death. He greatly improved the laboratory facilities of the hospital and was instrumental in elevating the standards of medical practice on the island of Kauai. He was dedicated to his work as a physician and pathologist and possessed a keen scientific curiosity which he did not permit the dull routine of rural practice to blunt. For a number of years he gave his attention to the influence of pinworms on appendicitis and was collating his material for publication just before his death. At the same time he was greatly interested in the influence of diet on atherosclerosis.

He was highly conscious of the tendency towards stagnation inherent in a rural practice and fought it with great vigor. Those of us who knew him greatly admired the courage and sincerity and personal integrity which he maintained in the face of the numerous difficulties that beset the pathologist in a rural community. With him, sincerity and friendship went hand in hand.

His hobbies were painting and sculpture, and several of his paintings decorate Wilcox Hospital. His artistry came to the fore on those occasions in which he planned the social activities of the Kauai County Medical Society, making these gatherings both unique and charming. Of late, he had been much interested in ornamental plants.

He was a member of both Wilcox Hospital medical staff and Kauai Veterans Memorial medical staff. He belonged to the Kauai County Medical Society, Hawaii Medical Association, American Academy of General Practice, Washington University School of Medicine Alumni, New York Academy of Sciences, and American Physicians Art Association. He was a senior surgeon in the Commissioned Officers Association of the United States Public Health Service. He was also a member of the Kauai Chamber of Commerce, Boy Scouts of America, Hanapepe Hongwanji, Kauai Canoe and Racing Association, American National Red Cross, Kauai Public Library, Young Men's Christian Association, and the University of Hawaii Alumni Association.

Doctor Masunaga died on December 5, 1960, of malignant brain tumor. He is survived by his wife, Ruth; daughter, Janet (Mrs. George Chun of Maryland); son, Edward Wayson; and brother, Minato. The funeral service was held at the Hanapepe Hongwanji. His death is a loss to Kauai. We have lost not only a doctor, but also a sincere and honest friend.

VERNON BOIDO, M.D.

County Society Reports

Kauai

The December meeting of the Kauai County Medical Society was held December 6, 1960, at 7:30 at the Wilcox Memorial Hospital.

Dr. Boyden gave the monthly report of the medical committee meeting of the Hawaii Medical Service Association.

Dr. Kim read a letter from Dr. Richard Lee, President, Board of Health, requesting the opinion of the members of our Society about the evidence of harmful effects from weed sprays used by the plantations. It was moved, and passed unanimously that there was no evidence at present that the weed sprays used by the plantations had created a public health menace. The membership requested the secretary to inform the Board of Health of this motion.

The following were elected as officers for the year 1961:

President	Dr. Cockett
Vice-President	Dr. Brennecke
Secretary-Treasurer	Dr. Goodhue

The membership asked the secretary-treasurer to allocate $15.00 for a gift for Dr. Kuhns to be given at the time of a dinner party next month. The membership asked the secretary-treasurer to write a letter of sympathy to Mrs. E. Masunaga. The secretary-treasurer was asked to allocate $25.00 for the expressions of condolences to the Masunaga family.

The scientific part of the program consisted of presentation of the film sponsored by Schering of the "Highlights of the AMA Annual Meeting in Miami in June, 1960."

Dr. Brennecke presented to the Wilcox Hospital Library the notes on a "Fluid Balance Clinic" held at the AMA meeting in Miami in June, 1960.

Each of the members of the Society was given a copy of "New Evidence on the Magnitude of Early Fetal Deaths," Fern E. French and Jessie M. Bierman, a paper based on the Kauai Pregnancy Study.

MARVIN A. BRENNECKE, M.D.
Secretary-Treasurer

Hawaii

On December 17, 1960, the Hilo Country Club was the gay setting for the annual Christmas get-together of the members of the Hawaii County Medical Society and their wives. With the fireplace burning, the Christmas tree lighted up, and the table loaded with gifts, a touch of white Christmas was present.

Dr. Hata conducted a brief business meeting. The recommendation of the Nominating Committee for officers for 1961 was unanimously accepted by voice vote. Dr. Samuel Haraguchi was elected President; Dr. Pete Okumoto, Vice-President; Dr. Francis Wong, Secretary; and Dr. Kay Ota, Treasurer.

Everyone enjoyed the thick juicy steak, and the fun-filled party conducted by Dr. Henry Yuen. The occasion was a hilarious and a memorable one.

TOKUSO TANIGUCHI, M.D.
Secretary

* * *

The January 26, 1961, meeting of the Hawaii County Medical Society was a dinner meeting at the Hilo Hotel. Dr. E. Cushnie, President of the Hawaii Medical Association, was present.

The meeting was called to order by President Samuel M. Haraguchi at 8:10 P.M. Several announcements were made by the President:

Four doctors in our society who have not registered with the Narcotics Bureau will be prosecuted according to law unless they register in the immediate future.

The annual essay contest sponsored by the American Association of Physicians and Surgeons will again be promoted by the society. The essay contest is opened to all 10th, 11th, and 12th grade students. The theme, as in the past, is "The Advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System." Dr. R. Miyamoto was appointed by the President as the Chairman of this contest.

Dr. E. Cushnie then spoke to the membership in regard to the proposed assessment of $15.00 a member to hire a public relations counselor for a period of one year. Dr. H. Yuen moved, seconded by Dr. T. Kutsunai, that the Society go on record approving the assessment of $15.00 for each member to help in paying the public relation counselor. The motion was carried unanimously.

Dr. E. Cushnie explained to the membership the problems confronting the Hawaii Medical Association this coming year. Among the topics discussed were: (1) Bureau of Medical Economics, (2) Stockton Plan, (3) Relative Value Fee Schedule, (4) White House Conference on the Aged, (5) Pending Legislation.

FRANCIS F. C. WONG, M.D.
Secretary

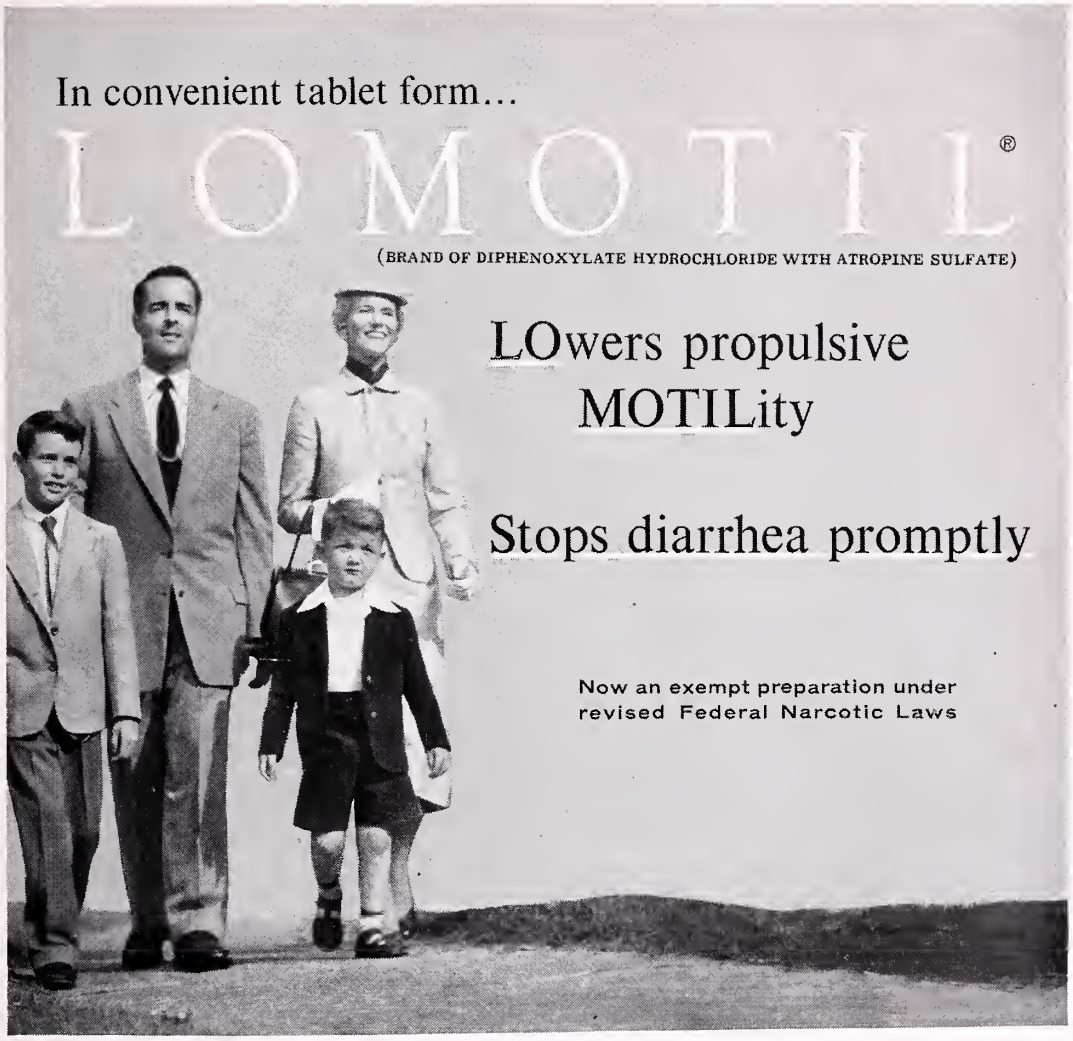
Honolulu

The Honolulu County Medical Society met on Tuesday, November 1, 1960, in the Mabel Smyth Auditorium, at 7:30 P.M.

The following new members were welcomed into the Medical Society by Dr. Pang: Dr. William A. Conover, Dr. Dorothy S. Uyeda, and Dr. Margaret K. Yamasaki.

Recommendations of the Fee Adjustment Committee approved by the Board of Governors and circulated to the membership were presented by Dr. Freeman and were acted upon as follows: (1) *Management of Artificial Kidney:* Recommendation—that the HMSA fee be on an indemnity basis with an allowance of $15.00 per hour while in attendance and that this procedure be placed under Medical Services rather than Surgical. The relative value schedule is recommended at 5.9 units per hour. *Discussion:* Dr. Faus stated that under this procedure, HMSA allows a maximum of 6 hours for physicians in attendance. It was brought out by the internal medicine men that they were not in accordance with Dr. Faus' statement as they felt that they should be paid for every hour spent on a case. Following further discussion it was the general feeling that this matter should be further clarified with the doctors who are doing it. It was moved, seconded and passed that this recommendation be referred back to the committee. *Pump Man:* Recommendation—that the relative value unit be 44.4 for perfusion only. It was moved, seconded and passed that this recommendation be accepted. *#3830 Perirenal Insufflation Unilateral or Bilateral:* Recommendation—that the relative value schedule be raised from 10.0 to 11.1 units. It was moved, seconded and passed that this change be accepted. *#2435 Arteriography (exclusive of x-ray allowance) lumbar:* Recommendation—that the relative value schedule be raised

(Continued on page 386)



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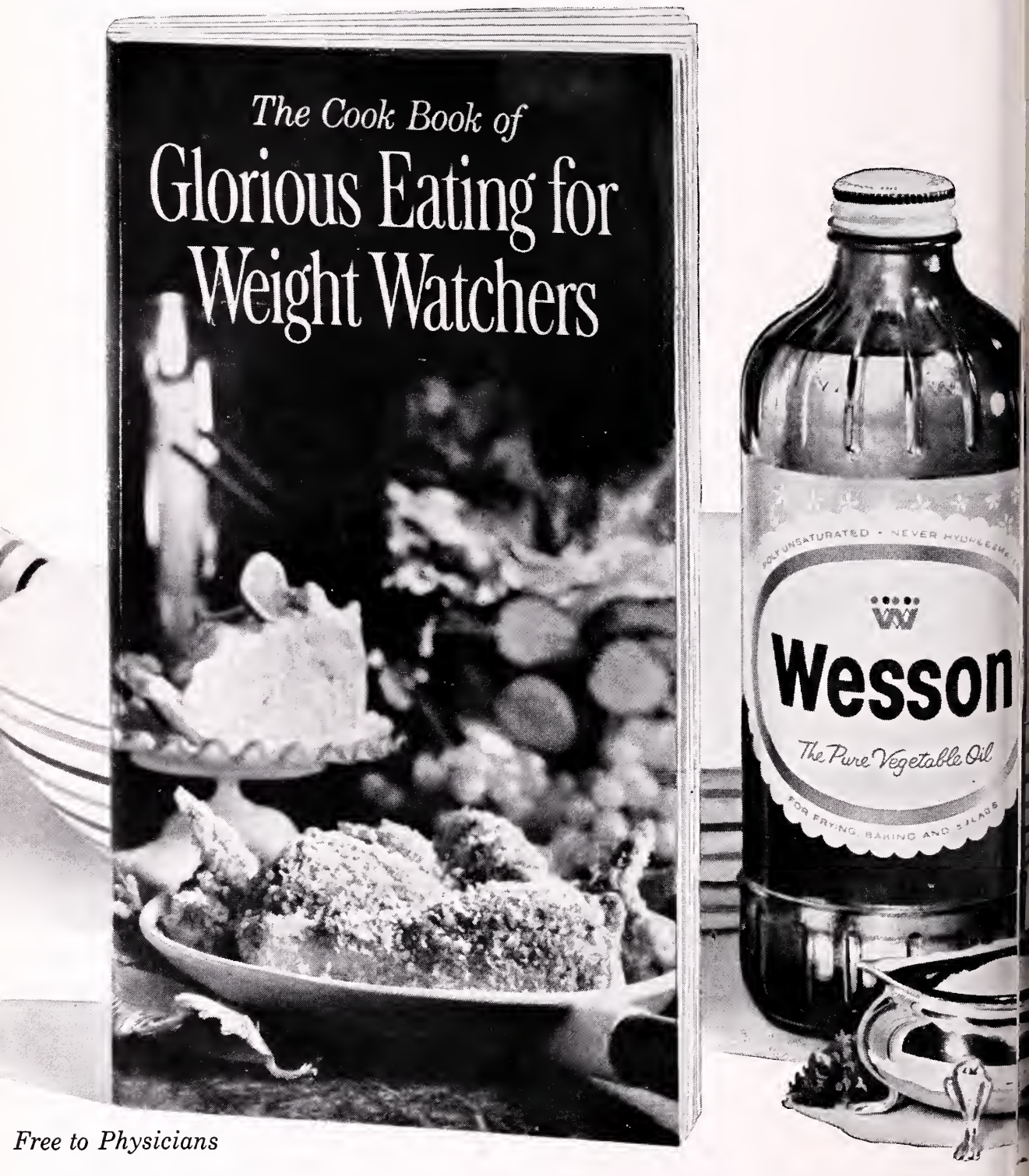
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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Hawaii Nurses Association

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HAZEL KIM, *Associate Edit*
MILDRED KIM, *Associate Edit*

OLIVE C. PRIDGEN, *Executive Secretary*

General Interest

At Your Service

The services of the American Nurses' Association Professional Counseling and Placement Service are now directly available to Hawaii nurses (ANA members and first-year professional nurse graduates) and employers through the national office at 10 Columbus Circle, New York 19, N.Y. We urge you to use this valuable professional service and we are ready to assist you in every way possible.

The ANA Professional Counseling and Placement Service is a nurse-centered service. The compilation and safekeeping of professional credentials of nurses is an important activity in itself. When a nurse indicates availability for placement, information about positions open is sent. If the nurse decides to apply for a position she or he asks PC&PS to send her professional biography, the summary of her education and experience, to the prospective employer for review. Please note that the nurse, not the employer, must make this request. Experience has shown that nurses who select positions carefully remain longer, realize greater job satisfaction, and contribute more to good patient care—the ultimate goal of all ANA activity.

Although the service is nurse-centered, this actually works to the employer's advantage. Every nursing position is a "key" position—to the hospital, to the public health agency, to industry, to schools. The selection of qualified personnel with demonstrated technical competence and skill in interpersonal relationships is a major task of employers but the hazards are reduced when the employer takes time to review the PC&PS record of a candidate's past performance.

When a nurse is employed, the PC&PS biography may be retained for confidential personnel files. If an applicant is not on file with PC&PS, the employer may ask her to have a record compiled and the summary forwarded as soon as possible. This is an important service to employers; there is no longer need to write for references, and evidence of the employee's suitability for employment is in the personnel files of the organization.

What are your obligations? Request application and PC&PS job description forms when needed. Once an application is filed, or a position listed, help us keep the information up to date.

ANA Economic Workshop

Olive C. Pridgen, executive secretary, Hawaii Nurses Association, returned last month from Ithaca, N. Y., where she attended a five-day conference sponsored by the American Nurses' Association. Eighty-six nurses from 46 states, including Alaska and Hawaii, were present at the meeting to study methods and techniques for improving salaries and working conditions of registered nurses.

The meeting was held at the Cornell University New York State School of Industrial and Labor Relations.

The group, consisting of representatives of state nurses associations and members of the ANA Committee on Economic and General Welfare, attended a daily class on economics and heard lecturers discuss trends in industrial and labor relations, public employment, merit systems, collective bargaining, grievance procedures and arbitration, financing health care through Blue Cross plans, factors in hospital personnel administration and building public and community relations.

Ida Klaus, legal counsel, New York City Department of Labor, told the nurses that 25 per cent of registered nurses in the country are employed by some segment of government. She said the reason public employees were denied the right to collective bargaining under the Wagner Act, national labor relations act passed in 1935, was that their conditions of employment were believed to be better than for those employed in private industry. She added this is not true today.

Miss Klaus believes the United States is moving toward collective bargaining for those in public

mployment and declared that public officials are eginning to understand the need to bring about eaceful relations and to eliminate public unrest. The public interest can best be served," she said, by stabilizing labor relations."

"Nothing in merit systems precludes the use of labor organization or collective bargaining," according to Paul P. Van Riper, professor of administration at Cornell. In a talk on the origin and unctioning of merit systems, he said, "(nurses) eed to recognize that this is an organizational orld and deal accordingly."

While public employees may not engage in partisan activity, Professor Van Riper said, organizations should learn to use political tactics and trategy to assure top calibre appointments to civil ervice commissions and government personnel gencies rather than "political hacks."

The Cornell professor urged the representatives f the state nurses associations to work to bring ll nurses in public employment under merit systems and to secure tenure protection. He also alled for continuing efforts to improve the rules overning their employment. "Too often," he aid, "such action by nurses comes after the rules ave been made."

"The right of collective bargaining is the law f the land," according to Eva Robins, mediator nd arbitrator for the New York State Board of Mediation. Miss Robins pointed out that collective bargaining can establish an effective climate n which to attain improvements in employment onditions. She cautioned the nurses to know as uch about the administration of a hospital as ne hospital administrator when they are in a egotiating situation. To bargain successfully, she id, nurses must understand their own aims and urposes and anticipate their future roles and oals. "It's not a question of what is nice to ave," she said, "but what are present and future ealities."

Jean T. McKelvey, Cornell professor of industrial and labor relations, spoke on grievance procedures and the role of arbitration. She pointed ut that nurses today are in the same position as ndustrial workers 20 years ago. Hospitals today re not covered by labor relations laws. However, Professor McKelvey predicted that in 10 years ollective bargaining will be accepted by hospitals or nonprofessional workers and probably for rofessional nurses. Hospitals are accepting many f the principles of collective bargaining and simiar procedures, she said, but they call them by ther names.

In addition to lack of legislative protection enoyed by other workers, and the highly organized pposition of their employers, many nurses themelves resist collective bargaining because of their fear of reprisal, said Mrs. Anne Zimmerman, executive secretary, Illinois State Nurses Association. Mrs. Zimmerman, also a member of the ANA board of directors, in summing up the obstacles to an effective economic security program for nurses, pointed out some of the trends that would assist nurses in overcoming these obstacles. Among these she listed: increasing public acceptance of the right to a voice in determining conditions of work and support for collective bargaining activity by community and religious organizations. Concluding, she said, ". . . as we move from the image of Florence Nightingale with lamp in hand, . . . and move toward the image of a responsible, educated nurse, a member of the community entitled to a voice in employment conditions, then we shall change resistance to insistence."

Although payroll costs account for the greatest rise in hospital care costs, salaries of professional and nonprofessional health workers are still inadequate, according to Bernard Backer, director of the statistical department, Martin Segal and Co., Inc., pension plan consultants, New York City.

In a talk on the status of health care financing through Blue Cross plans, he told the nurses that all groups—hospitals, the public and consumers of nursing—have a common interest in hospital care costs. It is not a question of keeping down hospital care costs, he said, but rather of providing the best types of hospital care. Mr. Backer called for widespread education in this area and said hospitals must become aware of the salary situation of their own employees while the public must understand the direct relationship of hospital care costs, Blue Cross charges and their own net income.

The nurse of the future will have more formal training, more prestige, will be a more professional person and accordingly will be better paid, according to Monsignor James A. Healy, professor of economics, D'Youville College, Buffalo, N. Y.

Father Healy was one of three speakers at a panel discussion on "Factors in Personnel Administration in Hospitals."

The other speakers were: Robert F. Risley, assistant dean of Cornell's New York State School of Industrial and Labor Relations, and Prof. Temple Burling, M.D., also of the Industrial and Labor Relations School.

Father Healy, economic consultant to several labor unions in New York State, said that the upgrading of nonprofessional hospital personnel through unionization or the "threat of unionization" would also bring, indirectly, economic benefits for nurses.

Father Healy also pointed out the increasing number of nonprofessional personnel being em-

ployed by hospitals. This means, he said, that more and more professional nurses' jobs are becoming administrative and supervisory.

As nurses wages are increased, he noted, more and more retired nurses will come back into nursing. At present, he said, paying the baby sitter and other expenses would eat up most of their earnings and hence they have little incentive to return to work.

Dr. Burling said that personnel administration in hospitals is influenced by the peculiar nature of these institutions which provide for the treatment of illness, serve as centers of research, and gradually are becoming the centers of all health care in communities. Today rapid changes are taking place in hospitals which have resulted in changes in the functions of all hospital personnel.

Dean Risley, who served as panel moderator, maintained that hospitals should not be considered too different from other industries in relations between employers and employees. Recently, hospitals have had to become more competitive in providing economic compensation for employees. There are growing pressures to minimize the differences between wages for hospital employees and those of other workers.

Each day's session began with a discussion of current economics by Theresa Wolfson, ANA economic consultant and professor of economics at Brooklyn College, New York. She pointed out that nurses should know about the economic situation in which they live because, in the years ahead, government will have to assume more responsibility in the health field and nurses ought to know how and where the money for this comes.

The conference ended with a session on building community relations at which David U. Snyder, ANA public relations counsel, was the speaker. Participants heard suggestions and discussion aimed at gaining community support for economic improvements.

Board of Nursing Moves Again

The Hawaii Board of Nursing moved its office to the Iolani Barracks on Hotel Street last September. It is housed with other regulatory boards in the Department of Treasury and Regulation which occupies the entire Iolani Barracks.

Miss Alison MacBride resigned as executive officer in October to fill the position of Community Services Supervisor for Mental Retardation in the Division of Mental Retardation in the State Department of Health.

Mrs. Mary Marshall Walsh was employed as Executive Officer for the Hawaii Board of Nursing in November. Mrs. Walsh is a former director of nursing at Children's Hospital.

Nurses Increase in Number

An estimated 504,000 professional nurses were employed in the United States in January, 1960 according to estimates of nursing supply prepared jointly by the American Nurses' Association, the National League for Nursing, and the U.S. Public Health Service. At least 90,000 of these nurses are employed part time; actually, this number is believed much higher because of the lack of complete data on part-time versus full-time employment.

The current estimate includes for the first time Alaska and Hawaii with a total of approximately 3,000 nurses. The last previous estimate, in January, 1958, showed 460,000 professional nurses employed in 48 states.

There are now 282 full- and part-time nurses per 100,000 population compared to 268 in 1958. Counting full-time nurses only, the figure is 231 nurses per 100,000 compared to 223 per 100,000 in 1958. The ratio of full-time professional nurses to the population is still far below what has been regarded as a reasonable goal of 300 nurses per 100,000 population.

The ratios of supply to population indicate an over-all general shortage of nurses, but do not reveal the crucial shortages existing in particular areas of nursing practice, notably teaching, supervision, and administration.

Numbers of nurses employed in hospitals and related institutions increased over the two-year period since the 1958 estimate, as did office nurses, public health nurses, and nursing educators.

Estimate of Professional Nurses Employed in the United States, by Field of Nursing, as of January 1958 and 1960:

FIELD OF NURSING	1958	1960[1]
Totals	460,000	504,000
Hospitals and related institutions	291,500	325,000
Private duty	70,000	70,200
Office	37,000	40,000
Public health	28,700	32,400
Occupational health	18,400	18,500
Nursing education[2]	12,400	14,200
Other	2,000	3,700

[1] Includes Alaska and Hawaii.
[2] Includes in-service education personnel.

Book Reviews

Practical Notes on Nursing Procedures, 3rd Ed.

By Jessie D. Britten, S.R.N., 199 pp., $4.00, The Williams & Wilkins Co., 1960.

British nursing practice, neatly outlined, with diagrams.

Occupational Health Nurses Section
of the
Hawaii Nurses Association

RULES

Rule 1. NAME

The name of this section shall be the Occupational Health urses Section of the Hawaii Nurses Association.

Rule 2. OBJECTIVES

The objectives of this section shall be:

a. To foster high standards of occupational health nursing actice.

b. To promote the welfare of occupational health nurses.

c. To provide an opportunity for the consideration of oblems of special interest to occupational health nurses.

d. To support and promote the aims and programs of the awaii Nurses Association.

Rule 3. FUNCTIONS

The functions of this section shall include the following:

a. To define qualifications for membership which are consistent with the general membership requirements of the awaii Nurses Association.

b. To make rules for its government, provided these shall no way conflict with the by-laws of the Hawaii Nurses ssociation; to submit them to the SNA committee on constitution and by-laws for review and to the Board of Directors for approval.

c. To cooperate with and assist the ANA section in defining and interpreting the functions, standards and qualifications for practice for its members, these to be developed for ch area of practice by the practitioners within it.

d. To initiate studies or experiments for the improvement practice of the members in relation to the overall purpose the Hawaii Nurses' Association and the American Nurses' ssociation.

e. To study the general welfare and economic needs of e members and develop desirable standards of employment d to promote the equalization of opportunities for all embers of this section regardless of race, color, or creed.

f. To organize subunits within the section in order that roups which have like interests shall have the opportunity f meeting to consider the economic security program separately from other groups in the same section whose economic terests might be somewhat different. The subunits shall ave the privilege of reporting directly to the Board of Directors of the Hawaii Nurses Association.

g. To represent the interests of its members in meetings f the association.

h. To develop relationships with allied professional groups r conferences or committee work related to the objectives f the Hawaii Nurses Association.

i. To conduct the programs of special interest to its members and to participate with other sections that have similar terests.

j. To organize branches for particular areas of practice nd/or conference groups on request for special interest beween sections.

k. To make pronouncements in the name of the section, rovided these pronouncements are not in opposition to the olicies accepted by the Hawaii Nurses Association, and do ot purport to represent the policies of the association as a hole.

l. To interpret all policies accepted by the Hawaii Nurses ssociation that affect the section and to publish these interpretations in the name of the section.

m. (1) To keep open direct channels of communication ith the Occupational Health Nurses Section of the American Nurses' Association and to submit simultaneously copies f such communication to the executive secretaries at state nd ANA headquarters.

(2) To keep open direct channels of communication with the Occupational Health Nurses Section of district associations and to submit simultaneously copies of such communication to the president and executive secretaries (or elected secretaries) of the district associations.

n. To elect delegates to biennial conventions and special meetings of the American Nurses' Association in conformity with Article X, Section 2 (a) of the American Nurses' Association Bylaws and Article XIII, Section 7, of the Hawaii Nurses Association Bylaws.[1]

Rule 4. MEMBERSHIP

Members[2] of the American Nurses' Association who are concerned in the health care of employed groups through (a) direct employment in commerce or industry; or (*b*) full time employment by an official or non-official agency for the purpose of promoting improved health care of employed groups; and (c) members who were engaged in occupational health nursing at the time of their retirement from nursing practice shall be eligible for membership in this section.[3] (For example: Nurses employed by Industrial and/or Commercial plants; Industrial Clinics; Industrial Physicians; Hospital Employee Health Services; Department Stores; Transportation Facilities; College Health Services; Hotels; Government Installations, etc.)

Rule 5. OFFICERS

A chairman, a first vice chairman and a secretary, each of whom shall be actively engaged in occupational health nursing.

Rule 6. DUTIES OF OFFICERS

a. The chairman shall preside at all meetings of the section, and the executive committee and be an ex officio member of all committees except the committee on nominations. The chairman shall be authorized to appoint any special committee necessary to further the work of the section, subject to the approval of the executive committee.

b. The first vice chairman shall perform the duties of the chairman in her absence,[4] shall become the chairman in case of a vacancy in that office, and shall assume such duties as may be delegated to her by the executive committee.

c. The secretary shall keep the minutes of all meetings, a copy of which shall be furnished the secretary of the State Nurses Association within two weeks following the meeting. The secretary shall write to the chairman of the district sections for occupational health nurses prior to the annual convention asking for suggestions for committee members for the work of the state section.

e. All officers will make available to their successors all pertinent section material within two weeks after termination of office.

Rule 7. EXECUTIVE COMMITTEE

a. There shall be an executive committee which shall consist of the chairman, the vice chairman, the secretary and a representative from each district group.

b. Regular meetings of the executive committee shall be held at the annual convention of the Hawaii Nurses Association at the place where such convention is held and at such other times as shall be determined by the executive committee.

c. Special meetings of the executive committee may be called by the chairman, on 5 days notice to each member either personally or by mail or by telegraph and shall be called by the chairman in like manner upon the written request of not less than 4 members of the executive committee. Special meetings shall be held at such time and place as may be specified in the notice.

d. In intervals between regular meetings of the executive committee, the chairman of the section may refer and submit to the members of the executive committee definite questions relating to the affairs of the section which require immediate action. The result of such referendum shall control the action of the executive committee.

Rule 8.
DUTIES OF THE EXECUTIVE COMMITTEE

The Executive Committee shall:

a. Appoint all standing committees except committee on nominations, and approve the appointment of all special committees.

b. Prepare the annual budget and provide for the expenditure of funds.

c. Review report of expenditures periodically.

d. Implement the functions of the section as set forth in these Rules.

e. Consider and act upon requests for organization of branches and/or subunits.

f. Fill any vacancies occurring on the committee on nominations and on the executive committee except that of chairman and vice chairman.

g. Be responsible for guidance of the section in the achievement of its objectives and the coordination of its activities.

h. Transact the general business of the section in the interim between regular meetings.

i. Act in an advisory capacity to districts in all section problems referred to this section of the Hawaii Nurses Association.

j. Develop relationships with other sections of the Hawaii Nurses Association and with departments in the Hawaii League for Nursing conferences or committee work relating to mutual problems.

k. Receive and review reports of branches and committees.

Rule 9. COMMITTEES

a. Standing committees shall be composed of at least three members of the section, and shall assume such duties as shall be specified in these Rules, and such other duties as may be assigned to them by the executive committee. Only active members shall be chairman of standing committees.

b. The following standing committees shall be appointed after each annual convention and shall serve until their respective successors are appointed.

(1) Committee on Functions, Standards and Qualifications for Practice
(2) Committee on Nominations (elected)
(3) Committee on Program
(4) Committee on Rules

c. The Committee on Functions, Standards and Qualifications for Practice shall cooperate and assist the corresponding committee of the Occupational Health Nurses Section of the American Nurses' Association to define and interpret the functions, standards and qualifications for practice within the fields of occupational health nursing. It shall guide and direct the work of the corresponding committees of the district sections for occupational health nurses. This committee shall be composed of active members only.

d. The Committee on Nominations shall consist of 4 active members of the section, one from each district. This committee shall prepare a ticket for each convention. The names of candidates who are members of the section, have consented to serve, and are qualified to fill the respective vacancies shall comprise the ticket as follows:

(1) Candidates for *each* of the following offices: chairman, vice chairman and secretary.
(2) Candidates from each district for Executive Committee.
(3) Four or more candidates for the committee on nominations.

Prior to the preparation of such a ticket, and before the scheduled date for the annual convention, the chairman of the committee on nominations shall request the membership of the section to submit names of persons qualified to fi vacancies.

In preparation of the ticket, the committee on nominatior shall give consideration to:

(1) Qualifications of candidates
(2) Number of districts submitting names
(3) Geographic distribution

The committee on nominations shall send the ticket of th Occupational Health Nurses Section to the headquarters c the Hawaii Nurses Association in such time that the tick can be circulated to the section membership. The ticket sha be presented to the members of the section at its first bus ness meeting during the annual convention, at which tim nominations from the floor may be added.

e. The Committee on Program shall receive suggestior from the section members for programs, and shall prepar programs for the regular meetings of the section. It sha submit the section's program for the convention meeting t the chairman of the committee on convention program c the Hawaii Nurses Association at a time designated by th chairman of the committee on convention program.

f. The Committee on Rules shall receive all propose amendments to these Rules and submit them to the exec tive committee and shall review district Rules and their rev sions and make recommendations to district sections.

Rule 10. SUBUNITS

a. Subunits shall be organized within the section in orde that groups which have like interests shall have the oppo tunity of meeting to consider the economic security progra separately from other groups in the same section whose ec nomic interests might be somewhat different. Such subuni shall have the privilege of reporting directly to the Hawa Nurses Association Board of Directors. The functions of subunit shall be to:

(1) Adopt employment standards for its members;
(2) cooperate with the SNA Board of Directors in the implementation of these standards;
(3) serve in an advisory capacity in all matters affecting the economic welfare of its members.

The officers of a subunit shall be a chairman and a secr tary, each of whom shall be actively engaged in occupation health nursing at the time of election, and who shall b elected annually by the members of the subunit.

b. A subunit committee on employment conditions, con posed of the chairman of the subunit and at least 2 activ elected members of the subunit, shall be formed as soon subunits are established. This committee shall:

(1) prepare tentative employment standards, or revise existing standards;
(2) present standards to the subunit membership for consideration and adoption; and
(3) may transact business of an urgent nature, pertainin to standards, between subunit meetings.

All transactions of this committee shall be reported in fu at the next regularly scheduled meeting of the subunit.

Rule 11. VOTING BODY

The voting body of any meeting of the occupational heal nurses section shall consist of the active members of t section who are in attendance and have submitted identific tion as active members of the section.

Rule 12. ELECTIONS

a. A chairman, secretary and representative from Haw and Oahu shall be elected in the odd years to serve for years or until their successors have been elected. A first vi chairman and representative from Maui and Kauai shall elected in the even years to serve 2 years or until their su cessors have been elected. Four members of the committ on nominations shall be elected annually to serve until th successors have been elected. Elections and voting on amen ments shall be upon identification of voters as active me bers of the section.[5]

b. Election shall be by ballot at the time and place pro-ded for the election by the Hawaii Nurses Association.
c. A plurality vote of the members of the section present, titled to vote and voting, shall constitute an election.
d. At the first business meeting of the section at the an-ıal convention, the chairman shall appoint tellers.
e. No member shall serve more than two consecutive rms in the same office.

Rule 13. MEETINGS

a. This section shall meet at such time and place as shall recommended by the section and approved by the execu-e committee of the section.
b. The annual meeting shall be held at the time and place the annual convention of the Hawaii Nurses Association.
c. Business meetings shall be open to members of the sec-n only, unless otherwise voted. Nonmembers if admitted, y have voice but no vote.

Rule 14. ORDER OF BUSINESS

The order of business for the annual meeting shall be:

a. Roll call
b. Reading of minutes of previous meeting
c. Report of committee on nominations
(1) Completion of ticket
(2) Introduction of candidates
d. Report of the chairman of the occupational health nurses section of the Hawaii Nurses Association
e. Report of other standing committees
(1) Report of Committee on Functions, Standards and Qualifications for Practice
(2) Report of Committee on Program
(3) Report of Committee on Rules
f. Reports of special committees
g. Reports of Conference Groups
h. Reports of chairmen of the occupational health nurses sections of district nurses associations
i. Unfinished business
j. New business
k. Report of tellers and introduction of new officers
l. Reading of minutes for correction
m. Adjournment

Rule 15. QUORUM

a. A quorum at any meeting of the section shall consist of one officer and members of the section, representing not less than 2 districts.
b. A quorum at any meeting of the executive committee shall consist of the majority of members.

Rule 16. AMENDMENTS

a. These rules may be amended at the annual meeting by two-thirds vote of the members present, entitled to vote and voting, provided the proposed amendments have been approved by the Board of Directors of the Hawaii Nurses Association and have been appended to call to the meeting.

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[1] These delegates may be elected from names suggested by district sections provided such procedure conforms with the Hawaii Nurses Association By-Laws.
[2] Unless otherwise specified, members shall be interpreted to include both active and associate.
[3] Since the Occupational Health Nurses Section is composed of nurse practitioners, it is appropriate that teachers in programs of study for occupational health nurses be invited to participate with the occupational health nurses section not on a membership basis but for the purpose of providing a channel for reciprocal communication.
[4] Does not apply to meetings of the Board of Directors of the Hawaii Nurses Association.
[5] This method promotes continuity of section activities.



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Isolyte® M Maintenance with 5% Dextrose For routine maintenance in adults and older children	50	40	35	—	—	—	40	20	—	—	15	180	400
Isolyte P Pediatric Maintenance For routine maintenance in infants and younger children	50	25	20	—	3	—	22	23	—	—	3	180	350
Isolyte E Extracellular Replacement in Water For replacement of intravascular, interstitial, transcellular losses other than gastric	—	140	10	5	3	—	103	—	47	8	—	10	320
Isolyte E Extracellular Replacement with 5% Dextrose For use as above	50	140	10	5	3	—	103	—	47	8	—	180	570
Isolyte G Gastric Replacement with 10% Dextrose For replacement of gastric loss due to suction or vomiting	100	63	17	—	—	70	150	—	—	—	—	340	800
Also 2 New Potassium Solutions: **Kadalex® L** (20 mEq. K^+ and Cl^-/L.) 0.15% Potassium Chloride with 5% Dextrose in Water	50	—	20	—	—	—	20	—	—	—	—	170	290
Kadalex M (40 mEq. K^+ and Cl^-/L.) 0.3% Potassium Chloride with 5% Dextrose in Water	50	—	40	—	—	—	40	—	—	—	—	170	330

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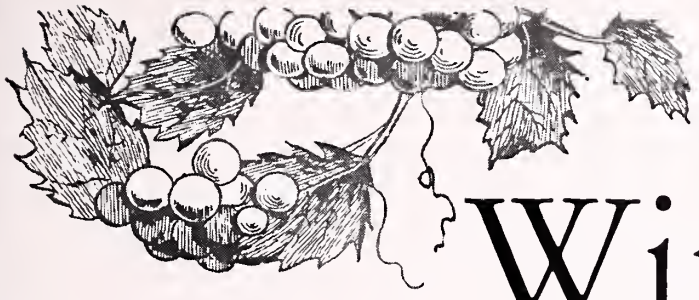
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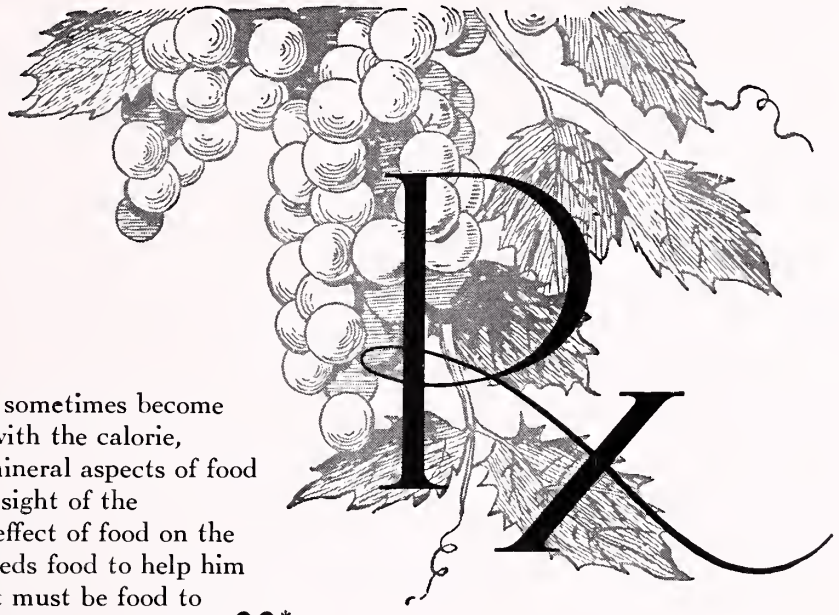
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By stimulating appetite, supplying quick energy source, relaxing tensions and increasing morale, the prudent use of wine has been described as balm for the convalescent and "milk" for the aged.

For a scientific discussion of the modern Rx uses for wine in convalescence, cardiology, urology, geriatrics, write for "Uses of Wine in Medical Practice," Wine Advisory Board, 717 Market Street, San Francisco 3, California.

*Floore, F. B.: Wine is Fine for Hospital Cookery, Mod. Hosp. 94:134 (June) 1960.

HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

CAROLYN E. MCCUE, *Editor* BERYL UYEHARA, *Associate Editor*

Post-Convention Conference

Have you stopped to give a thought to what you'll be doing from June 18 to June 22? These are the dates the Post-Convention Conference of your American Society of Medical Technologists will be held in Honolulu. This Post-Convention Conference will give you an opportunity to meet fellow members of ASMT from all over the mainland. Haven't you sometime or other wished you could attend the National Convention? This is your opportunity to talk to members from other states, to meet the officers, and to learn more about your national organization.

Besides all this, you will have the privilege of taking part in the exceptionally interesting program which has been planned by your State Society. There will be several speakers who will cover a wide variety of topics. Dr. Edwin Chung-Hoon will speak on "Racial Aspects of Hansen's Disease in Hawaii." Other speakers will be Dr. Walter Quisenberry, and Dr. Nils P. Larsen, as well as Drs. W. Harold Civin, I. L. Tilden and Max Levine.

The social side of the program has not been neglected either. The Conference will begin on Sunday evening, June 18, with a reception to welcome all our visitors. On Wednesday evening, June 21, there will be a luau. The official dinner will be held on Thursday, June 22. All meetings and events will take place at the Hawaiian Village, the official headquarters for the Conference.

The entire program is designed to be of interest to all and should prove most worthwhile. See you at the Hawaiian Village June 18 to June 23.

MARTHA EATON

Attention All Members

By this time you have probably received the information that has been sent out regarding the forthcoming National Convention and the Post-Convention Conference which is to be held here in Hawaii. Make your plans now so that you will be able to take part in the program planned by your State Society. Those dates are June 18 to June 23. Don't forget that as a member you will be an unofficial host or hostess to our visitors from the mainland. Give your State Society your wholehearted cooperation in making this Conference a success. See you at the Post-Convention Conference at the Hawaiian Village June 18 to June 23.

News Notes

There was no meeting of the Hawaii Society of Medical Technologists in January. . . .

In February another medical laboratory was established in Honolulu. It is part of the City County emergency unit now located in the new police station. . . .

Children's Hospital is setting up a calcium method using their new Spinco ultra-micro analysis system. . . .

Dr. Donough O'Brien of Colorado General Hospital, Denver, stopped briefly in Honolulu on his way to India. Dr. O'Brien, co-author of "A Laboratory Manual of Pediatric Biochemical Microtechniques," will be a professor of medicine in Madras. . . .

St. Francis Hospital Laboratory is now running pulmonary function studies using a Collins Respirometer. . . .

We would again like to urge society members working in the many laboratories around the Islands to contribute news items for the JOURNAL.

The T-3 Tests

T-3 (triiodothyronine) labeled with radioactive I-131 is used in the following in vitro tests of thyroid function:

I. Red cell uptake of I-131 T3.
II. Plasma thyro-binding determination, employing a labeled anion exchange resin.

Both procedures as they are done at Straub Clinic are presented here.

The method for the red cell uptake (Hamolsky modified by Robbins and Murphy) appears in the Nov.-Dec., 1959, issue of *American Journal of Medical Technology* in the article, "Routine Clinical Laboratory Use of An In Vitro Radioisotope Procedure," by Mary Elizabeth Murphy. It also appears in the October, 1959, *Journal of Clinical Endocrinology and Metabolism* on page 1292 and is entitled, "Experience with In Vitro Erythrocyte Uptake of I-131 Labeled 1-Triiodothyronine in a Routine Clinical Laboratory," by Leonard R. Robbins, M.D.

The method for the plasma thyro-binding determination employing a labeled resin was obtained from Dr. John F. Scholer, Palo Alto Medical Clinic, Palo Alto, California, in a personal communication to Dr. R. A. Nordyke.

The preceding article was contributed by Mrs. Alice Tonchen, radioisotope chemist at Straub Clinic.

Red Cell Uptake of I-131 T3

rocedure:

1. Withdraw 5 ml of blood in a test tube containing an anticoagulant. Potassium oxalate, mixed oxalate, heparin, ACD solution, or EDTA may be used. Perform test as soon as possible.
2. Prepare fresh buffered saline by mixing 1 part saline with 1 part M/15 Phosphate Buffer, pH 7.4.
3. Dilute stock radio-1-triiodothyronine (Triomet, Abbott Laboratories, or Tri thyrotope, Squibb) with enough buffered saline to yield 30,000 to 50,000 counts per minute per 0.1 ml. The following formula is used to calculate the amount of buffered saline required to dilute 0.05 ml of stock.
   mc/ml stock solution $\times 0.133 \times$ decay factor = ml of buffered saline. Prepare on day of test only.
4. Pipet 1.0 ml blood samples into 15×125 mm test tubes. Tests are performed in duplicate or triplicate.
5. Add 0.1 ml dilute T3 to each tube.
6. Shake tubes at 37° C for two hours.
7. Determine the hematocrit.
8. Count each sample in well counter and correct for background.
9. Centrifuge for 4 min at 4,000 rpm. Remove supernatant plasma.
10. Wash the cells five times with 5 ml saline. Once the washing process is started it must be completed without delay.
11. Count the washed cells in a well counter and correct for background.

lculations:

$$\frac{\text{Net counts of washed cells}}{\text{Net counts of whole blood} \times \text{hematocrit}} \times 100 = \text{\% T3 Red Cell Uptake}$$

anges:

	F	M
Euthyroid	11-17	12-19
Hypothyroid	6-11	5.5-11.6
Hyperthyroid	17-35	19.5-37.9

The effects of various factors on the red cell uptake e as follows:

ecrease:

A. Pregnancy
B. Menstruation
C. Estrogen therapy
D. Propylthiouracil in hyperthyroidism
E. Iodide in hyperthyroidism

o (or slight) effect:

A. Thyroid enlargement—colloid goiter, nontoxic nodular goiter, thyroid carcinoma
B. Exogenous iodine (except where iodide in amounts which cause a reduced hormone secretion is given)
C. Anxiety
D. Congestive heart failure
E. Hypertension
F. Administration of mercury
G. Other endocrinopathies—diabetes mellitus, Addison's disease

ıcrease:

A. Anticoagulants—dicumarol, heparin
B. Nephrosis
C. Severe liver disease
D. Severe metastatic malignancy
E. Severe pulmonary insufficiency with CO_2 retention
F. Paroxysmal atrial arrhythmias

Plasma Thyro-Binding Determination

Preparation of the labeled resin:

In a 25 ml flask place:
- 15 ml distilled water
- 2.5 microcuries of I-131 labeled 1-triiodothyronine (The original method calls for 2.5 micrograms but resulting activity in the resin was too much for our well counter)
- 7.2 grams (5 grams dry weight) of strongly basic anion exchange resin (IRA 400), salt form

Shake the mixture at 37° C for 30 minutes
Filter through Whatman 42 paper using a Buchner funnel
Transfer resin to a beaker
Wash with 15 ml water and filter again
Allow to dry at room temperature
The labeled resin may be kept at room temperature until used but not longer than two weeks.

Procedure:

Into 15×125 mm test tubes:
1. Weigh approx. 0.1 gm labeled resin
2. Count in well counter and correct for background
3. Add 2.0 ml plasma (anticoagulant—EDTA or double oxalate, but not heparin)
4. Shake the tubes at 37° C for 2 hours
5. Centrifuge for a few minutes
6. Remove 1 ml plasma and place into another 15×125 mm test tube
7. Count in well counter and correct for background

Calculations:

$$\frac{\text{Net counts in 1 ml plasma} \times 2}{\text{Net counts in 0.1 gm labeled resin}} \times 100 = \text{\% "thyro-binding" by plasma}$$

The original method calls for counting all the tubes and determining the activity of the resin in microcuries. "Any tube in which the activity varies from the mean by more than 10% is discarded. The assayed tubes are then kept at room temperature until used. . . ."

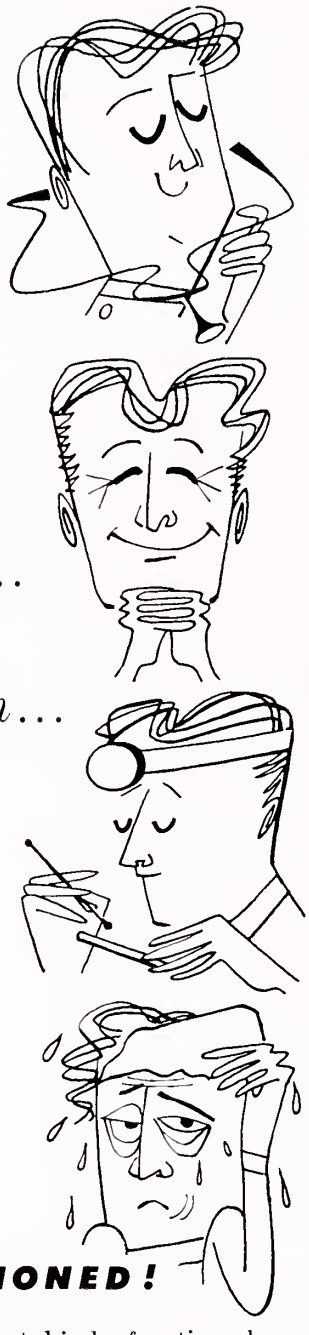
Calculations:

$$\frac{2 \times \text{microcuries in 1 cc of plasma} \times 100}{\text{total microcuries in tube (corrected for decay)}} = \text{\% "thyro-binding" by plasma}$$

"In euthyroid individuals, the average per cent of thyro-binding by the plasma has been about 11%. . . .

". . . The pooled standard plasma is kept frozen until used. With each test run, the per cent thyro-binding of this standard plasma is determined in triplicate, and the per cent thyro-binding of each test sample is divided by their mean. The results of each test are expressed as a 'thyro-binding index' in which the value of the standard pooled plasma is, of course, unity, in which plasma with high binding power has a high index, and that with low binding power a low index."

	HYPERTHYROID	EUTHYROID	HYPOTHYROID OR PREGNANT
Range of value	less than .86	.86 to 1.20	greater than 1.20



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NOTES AND NEWS

(Continued from page 365)

made valiant efforts to secure a long-delayed boost in th new industrial accident fee schedule.

Dr. James E. Mitchell of Kealakekua publicly defende the future of education for Kona's children.

Congratulations

Drs. R. L. Lichter and **D. P. Jones** for receiving certifica tions in orthopedics this past January.

Dr. Joseph Nishimoto of Pearl City as being selected a one of ten outstanding Jaycees of the State for 196(Kudos to **Dr. David Katsuki** for his reappointment a Director of the City Health Department. After battlin for years, **Dr. Alvin A. Majoska** has finally seen fruits o his work: the need for a City Medical Examiner. No on else but he himself is the new Medical Examiner. Cor gratulations!

Congratulations to **Dr. Raymond C. Yap,** whose pro jected 30-story Metropolitan Tower Bldg. on Kapiolan Blvd. received top national award for design in the an nual "Progressive Architecture" competition.

Dr. R. C. Spencer, chief of the Mental Health Divisior on his commission as a Lieutenant Colonel in the Unite States Army Reserve. Also **Dr. F. C. Spencer,** reelecte President of the Oahu Cytology Lab; to **Dr. G. W. Henry** for having recently been elected Fellow in the America College of Radiology; and to **Dr. H. Y. Y. Chinn,** newl elected president of the See Dai Soo Society for 1961.

(Continued on page 384)

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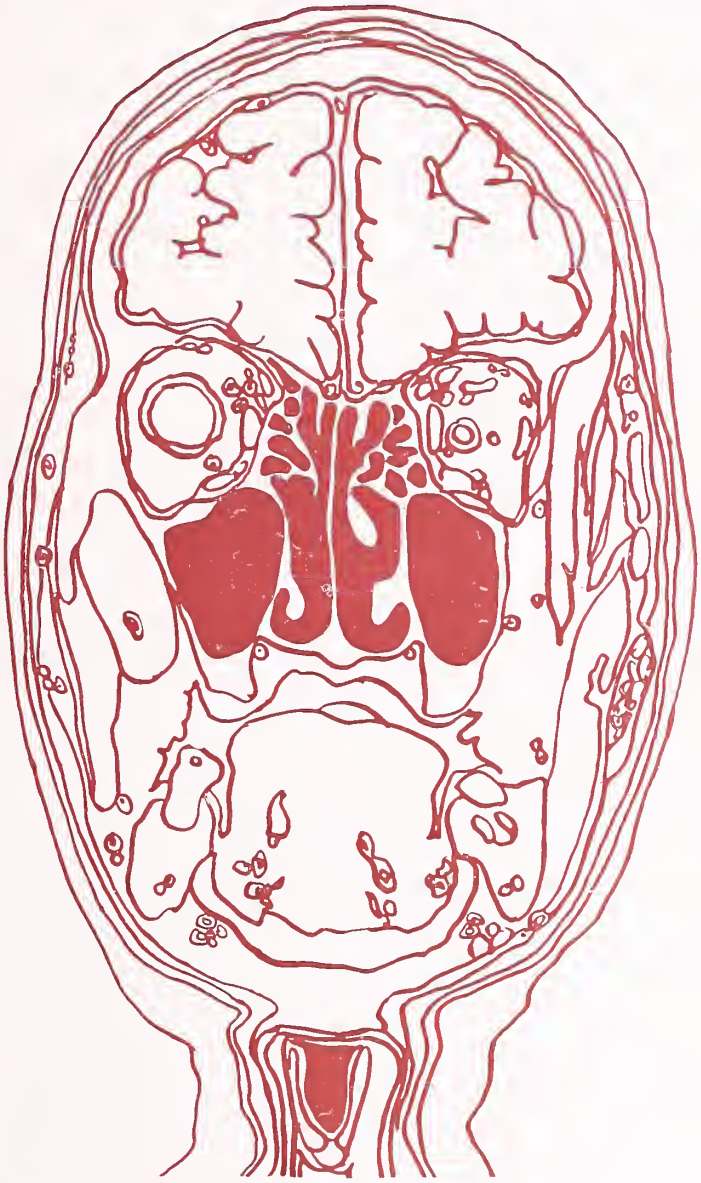
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HAWAII PHARMACISTS' BULLETIN

Official Publication of the Hawaii Pharmaceutical Association

A General Membership Dinner Meeting of the Hawaii Pharmaceutical Association was held at the Reef Hotel on Thursday evening, February 9, 1961. Dr. Charles Silva and Mr. Rodney Gudgel from the Department of Treasury and Regulations and Mr. Kenneth Lum and Mr. Sidney Kosasa from the Board of Pharmacy discussed some of the proposed amendments to the pharmacy law. Mr. Abel Fraga, State Narcotics Investigator, and Mr. William Grady, Federal Narcotics Investigator, discussed recent changes in the narcotics regulations. Mr. George Akau, Chief of the Pure Food and Drugs, spoke on pharmacy regulations. A question and answer period followed the presentation of these talks.

The program for the Fifth Annual Hawaii Pharmaceutical Convention to be held at the Reef Hotel from May 17 to 20, 1961 is being formulated. There will be addresses given by several prominent pharmaceutical industry speakers. The speakers include Frank H. Pratt, Director of Sales of Ciba; Ed Brady, Director of Sales and Trade Relations of Mead Johnson; Northam Warren, Jr., President of Northam Warren Corporation; Charles K. Piercy, Domestic Sales Manager Lederle Laboratories Division, American Cyanamid Co.; and Nelson Yarbourough, Manager of U. S. Sales Operations.

The social activities will include a cocktail party at the Pacific Club, Golf Tournament at the Oahu Country Club, Chinese dinner at the Long House Hilton Hawaiian Village, and the Aloha Banquet at the Reef Hotel.

For the ladies, a special program, which includes a fashion show and luncheon, is being planned.

Brochures containing information about the convention have been sent to the various state pharmaceutical associations and other national pharmaceutical organizations. A large representation of mainland pharmacists as well as local pharmacists is anticipated.

Doctors, Dentists, and Druggists Golf Tournament is tentatively scheduled for Thursday, March 30, 1961, at the Waialae Country Club. The tournament this year is being planned by the Hawaii State Dental Association. Dr. Raymond Tachibana is chairman.

5th ANNUAL PHARMACEUTICAL CONVENTION

IN HONOLULU, HAWAII

May 14 to 21, 1961

Itinerary

WED., May 10—Lv. San Francisco SS "MATSONIA."

MON., May 15—Ar. Honolulu. You will be welcomed by a traditional "Aloha" greeting with fresh flower leis and hula girls. Transfer to the REEF HOTEL, "on the beach at Waikiki."

— OR —

SUN., May 14—Jet flight over the Pacific from Los Angeles, San Francisco, Portland, Seattle or Vancouver to Honolulu to participate in the 5th Annual Pharmaceutical Convention in the enchanting Hawaiian Islands. You will be welcomed by a traditional "Aloha" greeting with fresh flower leis and hula girls. Transfer to the REEF HOTEL—"on the beach at Waikiki."

MON., May 15, 9 a.m.-10 a.m.—Registration in Reef Hotel Lobby.

1:00 p.m.—Transfer from Reef Hotel to the Sampan fishing harbor at Kewalo Basin. Embark on the cruiser "ADVENTURE" for trip to historic Pearl Harbor, along "Battle Ship Row," passing the submerged USS ARIZONA where a memorial is being erected to the 1102 officers and crew entombed as a result of the December 7, 1941 bombing.

TUES., May 16—Morning at leisure to swim, visit the Bishop Museum, Honolulu Academy of Arts, Ala Moana Shopping Center, The Aquarium, Zoo or just plain loaf.

2:00 p.m.—Depart on a tour of the island of Oahu visiting famous Nuuanu Pali, where King Kamehameha's conquering army pushed the Oahuans "over the Pali" (cliff), along the windward side of the island through banana plantations, papaya groves ("Princess Pupule gave them away"), past ancient Hawaiian fishponds, the Mormon Temple at Laie through vast sugar and pineapple plantations, Schofield Barracks, skirting the shores of Pearl Harbor through downtown Honolulu with its palm trees, City Hall, Kawaiahao Church, Iolani Palace, former Royal Palace of Hawaii's monarchy (only royal resi-

ence on American soil) to your hotel in time for a late swim at Waikiki.

ED., May 17—At leisure. On this date, delegates to the Convention from Islands of Kauai, Maui and Hawaii will register.

URS., May 18, 9:00 a.m.—First business session of the Convention.

12:00 noon—Luncheon with address by an outstanding speaker of the Pharmaceutical industry.

6:00 p.m.—Cocktail Party for all delegates.

I., May 19, 9:00 a.m.—Business Session.

12:00 noon—Luncheon with another industry speaker.

2:00 p.m.—Golf Tournament.

6:00 p.m.—Transfer from hotel to Lau Yee Chai, famous Chinese restaurant, for a nine-course, Mandarin dinner.

T., May 20—Day at leisure for shopping, swimming or what-have-you.

6:30 p.m.—Aloha Banquet at Reef Hotel.

N., May 21—Morning at leisure. Transfer to airport for those returning by air.

ON., May 22—Morning at leisure.

2:00 p.m.—Transfer for those returning by SS LURLINE to Pier 9, due San Francisco May 27.

Hawaii . . .

Beautiful islands in a beautiful setting! Imposing Diamond Head overshadowing Honolulu—the white crescent-shaped beach at Waikiki—majestic palms and myriads of flowers—colorful leis and graceful hula girls—outriggers and catamarans skimming the surf—pleasant sunshine and the blue, blue Pacific!

Now you can enjoy Hawaii's superb enchantment while attending the 5th Annual Hawaiian Pharmaceutical Convention in Honolulu—with all the travel details pre-arranged by the Travel Department, Theo. H. Davies & Co., Ltd., P. O. Box 3020, Honolulu 2, Hawaii. Guests and friends of druggists are also invited to attend.

You will travel over the blue Pacific by Matson Line steamer or United, Northwest, PAA or Canadian Pacific jetliners, enjoy the hospitality of a deluxe Waikiki hotel, attend informative business sessions specially arranged by the Convention Committee, attend a Chinese Mandarin dinner, a get-together cocktail party, two luncheons and a farewell banquet. In addition you will tour the Island of Oahu, visit Pearl Harbor and have the opportunity at the conclusion of the Convention to tour the attractive outer islands.



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NOTES AND NEWS

(Continued from page 380)

New Affiliations

Dr. Theodore Tomita has relocated to spanking new offices at the Professional Center Building in Waipahu. **Dr. Takeo Fujii,** formerly of South King Street, will be in association at the same address. **Dr. Minoru Kimura** finally moved into his new building, The Kalihi Medical Center, at his former address on 1833 N. King St. New affiliate there will be **Dr. Sidney Fujita,** obstetrician.

Dr. Lyle Bachman has resigned from the Fronk Clinic and opened offices in the Professional Center Building. **Fronk Clinic's** new building on South Beretania Street is approaching completion. **Dr. Gerald S. Laros** has joined the Medical Group in orthopedics and **Dr. A. E. McGinnis** has left the islands. **Dr. Margaret K. Yamasaki** has announced the opening of offices in the practice of ophthalmology in the King Center Building. **Dr. Henrietta Tompkins** has relocated to the Waikiki Medical Building. **Dr. Allan H. W. Young** has also moved to the King Center Building. **Dr. Shigeo Natori** has opened a branch office in Pearl City. **Dr. Arthur J. Okinaka,** general surgeon, announced the opening of his offices at 1409 Kalakaua Avenue.

Travel News

Dr. and Mrs. Verne C. Waite attended the American College of Surgery meeting in Mexico City and also visited friends in Dallas, Palm Springs, Los Angeles, and San Francisco. **Dr. and Mrs. B. Allen Richardson** on their way to The American Academy of Orthopedic Surgeon Convention visited many places—San Francisco, Los A geles, New Orleans, Miami, Nassau, and New York.

Dr. and Mrs. Ralph B. Cloward spent five weeks on t mainland on a medical-social whirl, returning exhaust they dashed to Kauai (Coco Palms) to rest.

Dr. S. Yamauchi, one of Hawaii's delegates to t White House Conference on Aging, reports a busy ed cational trip to Washington, D. C. He departed early visit and investigate other areas of the county to see ho they are handling the problem of the care of the age Prominent at the White House Conference were **D Norman Sloan,** a member of the President's Commissi on Aging, and **Dr. Leo Bernstein,** representing Governo Quinn. In addition to his trip to the inaugural in Wash ington, D. C., **Dr. Richard You** also attended the Nation AAU meeting in Las Vegas, Nevada.

Dr. Richard K. C. Lee was a U. S. delegate to the 14 World Health Assembly in New Delhi, India, Februa 7 to 14.

Dr. F. J. Pinkerton made a one-day trip to San Fra cisco recently. **Dr. R. Varian Sloan** attended the Americ Academy of General Practice Committee on Educatio spring meeting as well as the 57th Congress of Medic Education and Licensure in Chicago recently.

TB and Chest Disease Course

The Trudeau School of Tuberculosis and Other P monary Diseases, which will hold its Forty-sixth Sessi in Saranac Lake, N. Y., from June 5 to 23.

Inquiries should be addressed to the Secretary, Tr deau School of Tuberculosis and Other Pulmonary D eases, Box 670, Saranac Lake, N. Y.



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COUNTY SOCIETY REPORTS

(Continued from page 366)

from 10.0 to 11.1 units. It was moved, seconded and passed that this change be accepted. *#3820 Renal Biopsy (by trochar or needle):* Recommendation—that the HMSA fee be raised to $35.00 including aftercare but that the relative value schedule remain the same at 3.0 units. It was moved, seconded and passed that this change to the HMSA fee schedule be accepted. *Major Medical Fee:* HMSA Medical Committee has requested that the Society provide them with guide lines to determine "reasonable fees" for intensive medical care and surgical cases in Hawaii. Recommendation—it is recommended that a reasonable fee would be one based on 100% of the full relative value schedule. *Discussion:* It was brought out by the Internal Medicine men that to ask them to accept the above recommendation would be like asking them to enter into a contract with HMSA on a fixed fee basis. It was also felt that our relative value schedule should be revised upwards when applied to intensive medical and surgical care and that the Fee Adjustment Committee should get together with the various specialty societies to discuss their fees. It was moved, seconded and passed that this recommendation be referred back to the Fee Adjustment Committee. *Repair of tendo-achilles:* Recommendation— that this procedure be included in the HMSA schedule under #1634 with a relative value of 30.0 units. It was moved, seconded and passed that this recommendation be approved. *Myringoplasty:* Recommendation—that this procedure cover all cases of myringoplasty with no reference made to the degree of perforation in the tympanic membrane and that the fee be $125.00. Following a brief discussion it was felt that the Otolaryngologist should be consulted in regard to this recommendation, and it was moved, seconded and passed that this recommendation be referred back to the Fee Adjustment Committee.

Dr. Morton Berk, Chairman of the Medical Care Plans Committee, presented to the membership a brief history of the Foundation for Medical Care plan, more commonly known as the "Stockton Plan," information on which had been circulated to the membership. He reviewed in detail the Foundation Plan taking into consideration the philosophical concept, principles in adopting a fee schedule, administration and control, foundation costs, participating membership and the foundation's role, and its service concept. He stated that a few years ago another Medical Care Plans Committee had submitted a comprehensive report of the Foundation Plan to the Board of Governors for approval but was turned down. He further stated that his committee was instr ted to review this plan again and after spending m hours in reviewing this plan, including the findings Mr. Kennedy who was asked to check into several Fo dation Plans on the West Coast during a recent trip, committee unanimously agreed that such a plan ha great deal of merit and that action should be taken the Society to initiate a Foundation for Medical C here in Hawaii. Following a lengthy pro and con cussion it was the general feeling of the members that this plan should be explored further. It was mo by Dr. Ando that the Honolulu County Medical Soci approve the Foundation Plan in principle and instr the Medical Care Plans Committee to draw up the tails of this Foundation Plan for final approval bv Society. The motion was seconded and was passed.

O. D. PINKERTON, M.D
Secretary

* * *

The Honolulu County Medical Society met on Tu day, December 6, 1960, in the Mabel Smyth Auditoriu The meeting was called to order by President H. Pang at 7:45 P.M. Approximately 180 members w present.

Dr. George Suzuki, new active member, was int duced.

Election was held by ballot. Adequate time was giv for nominations from the floor.

The Chair announced that the annual reports of officers and committee chairmen had been circulated the mail for the first time this year and that if th were no objections from the floor all reports wo stand approved as circulated. Committee recommen tions requiring membership approval were acted up as follows:

Treasurer and Finance Committee: Recommendat —that the outgoing treasurer prepare the budget the coming year to be submitted to the new slate officers for their approval and that continued stu be given to the problem of the inter-relationships the Bureau of Medical Economics, a profit-mak organization, and the Society, an eleemosynary in tution, regarding the numerous legal and tax aspe involved and with the aim of increasing the bene to the medical profession.

It was moved, seconded and carried that this rec ommendation be approved.

Fee Adjustment Committee: Recommendation—t the committee be enlarged to include one meml

(Continued on page 390)

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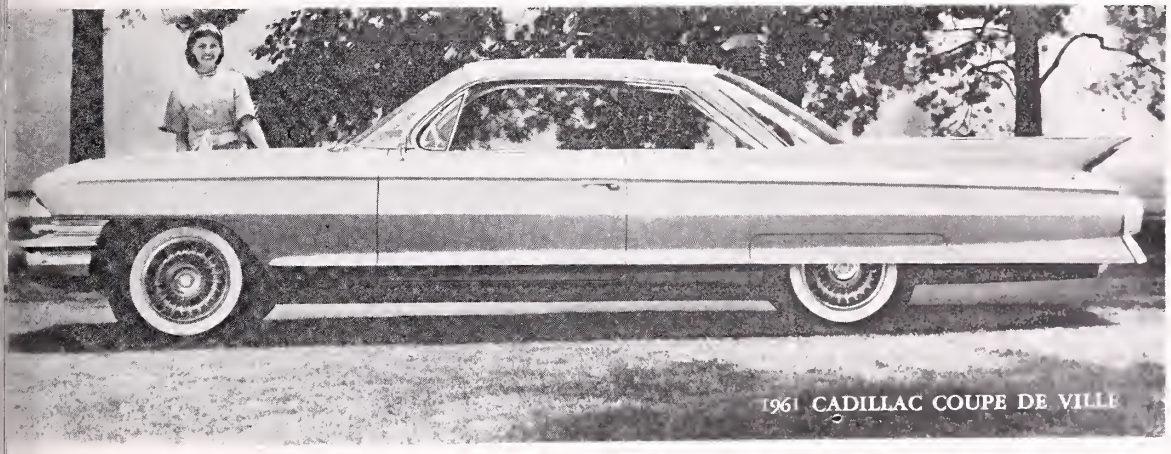


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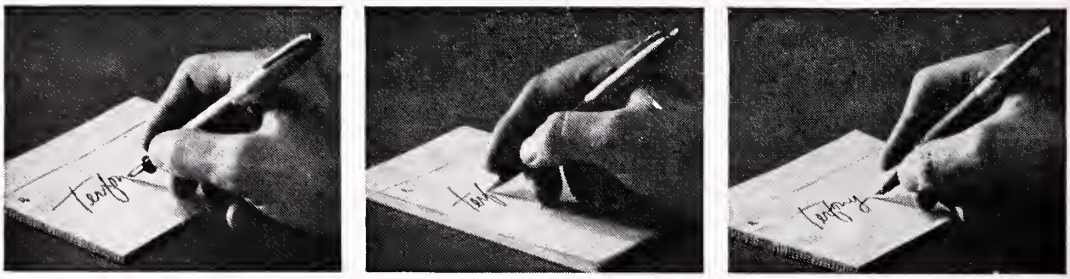
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COUNTY SOCIETY REPORTS

(Continued from page 386)

from each specialty and a member from the gene practitioners and that as each member goes off th should be replaced by another member of the sa specialty. It was brought out that this change wo be provided for in the Bylaws.

It was moved, seconded and carried that this rec ommendation be approved.

Medical Care Plans Committee: Recommendation addition of one or possibly two members to this co mittee.

It was moved, seconded and passed that this rec ommendation be approved.

Program Committee: Recommendation—that the S ciety direct the officers and Board of Governors detail for Society's action the privilege and duties membership so that the Society can become a m informed and effective organization in raising furth the standards of medical care and professional a community responsibility of its members; and (that one membership meeting a year be devoted t social function where wives are invited.

It was moved, seconded and carried that the two recommendations be approved.

Public Service Committee: Recommendation—that Medical Forums be continued if co-sponsored w the *Honolulu Advertiser* and that the "Drugs Dooley" project be revived and publicized.

It was moved, seconded and carried that both recommendations be approved.

Legislative Committee: Recommendation—that the ciety undertake immediately a survey of the differ income groups to determine how much is spent medical care, entertainment, mortgages, alcohol, arettes, and other basic necessities of life by empl ing such agencies as Craig Associates in order t these facts and figures may be presented to the n Legislature.

Dr. Sloan brought out that the Legislature conve in February and although this recommendation ha great deal of merit he felt that a survey of this ture would require more time to complete.

Dr. Sloan moved that the Board of Governors b apprised of this matter and further action by th Board be taken on this recommendation. The mo tion was seconded and was passed.

A red carnation lei was presented to Mrs. Herbert Pang, President of the Woman's Auxiliary, in reco tion of the Auxiliary's services to the medical profess

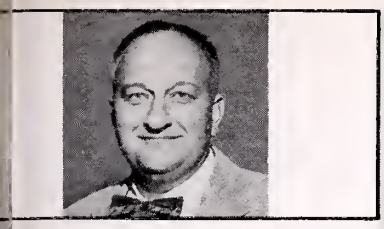
Upon the recommendation of the Finance Commi that the annual dues of active and inactive members the year 1961 be fixed at $70.00 and $12.00, it moved, seconded and carried that the committee's ommendation be approved.

The doctors were reminded of the attractiveness the Group Life Insurance Plan for the Society and send in their applications. It was mentioned that so only 55 applications have been received.

Society members were invited to attend the mont professional staff meeting of the Tripler Army Hosp on December 13 at 7:30 P.M. Speaker Dr. Edmund Overstreet, professor of OB&GYN, University of C fornia Medical School, will speak on "Hirsutism Women."

Dr. Nishigaya announced that the rehabilitation p

(Continued on page 392)



CHARLES MALANG
Monoger



MYRNA FO
Secretory



GEORGE PERIERA
Buyer



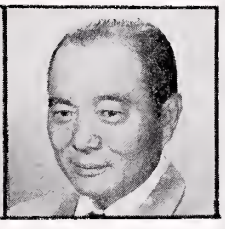
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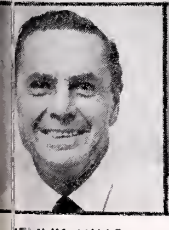
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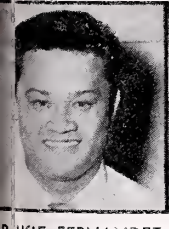
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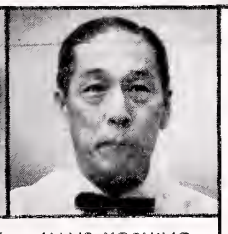
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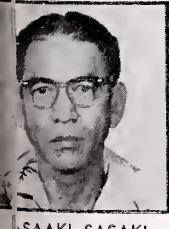
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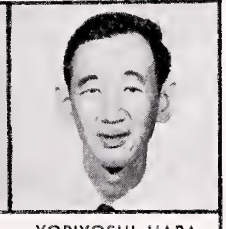
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COUNTY SOCIETY REPORTS

(Continued from page 390)

gram has recently expanded and asked that any physician who has patients in the hospital requiring rehabilitation to get in touch with the Rehabilitation Review Committee of the HMA which has indicated that it can handle more referrals.

A preview of the 1960 golf tournament of the Hawaii Medical Association was shown plus another golf film taken back in the 30's. A bottle of Scotch was given the lucky winner who guessed the correct year.

Mr. Richard Kennedy presented his annual report to the Society, a copy of which is on file.

Dr. H. Q. Pang presented in addition to his president's report which had been circulated some remarks concerning the Society's adoption of the Stockton Plan and some of the questions and reactions posed by the membership.

Election Results:

Results of the election were announced by the Chair as follows:

PRESIDENT-ELECT
O. D. Pinkerton

SECRETARY
R. D. Moore

TREASURER
T. Tomita

BOARD OE GOVERNORS—2 years
H. Chinn, S. Nishijima, W. Stevens, T. P. Frissell

ALTERNATE BOARD OF GOVERNORS—1 year
B. Fong, U. Goto, R. Rose

BOARD OE CENSORS—3 years
Robert D. Millard

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The newly elected officers were duly installed by D T. Nishigaya and were presented with red carnation le by members of the Woman's Auxiliary. The present tion of the gavel to President Hartwell was followed l the presentation of an engraved plaque to outgoi president Dr. H. Q. Pang for his leadership and servi to the Medical Society this past year.

President Hartwell presented a brief message to t membership and showed some slides taken at the annu picnics of the HMA of small groups of doctors w were humorously described as various boards and co mittees of the Medical Society.

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*MC GOVERN, J. P., MC ELHENNEY, T. R., HALL, T. R., AND BURDON, K. D.: ANNALS OF ALLERGY 17:915, 1959.

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(Continued from page 363)

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The Surgical Clinics of North America, Vol. 40, No. 5

Walter C. MacKenzie, M.D., Guest Editor, pp. 1 1466, W. B. Saunders Co., October, 1960.

A Canadian symposium on the care of various gical emergencies which require immediate managem

The Medical Clinics of North America, Vol. 44, No. 5

Pp. 1137-1157, W. B. Saunders Co., September, 196

New concepts in the application of basic scienc effective treatment from The Peter Bent Brigham H pital.

Rypins' Medical Licensure Examinations

Edited by Walter L. Bierring, M.D., 805 pp., $11.0 B. Lippincott Company, 1960.

Probably useful for reviewing for the Boards. hopes that *most* candidates who pass could have n aged without such help, however.

Electrocardiographic Techniques

By Kurt Schnitzer, M.D., 101 pp., $4.75, Grune Stratton, 1960.

A simplified manual aimed at nurses and technic

(Continued on page 398)



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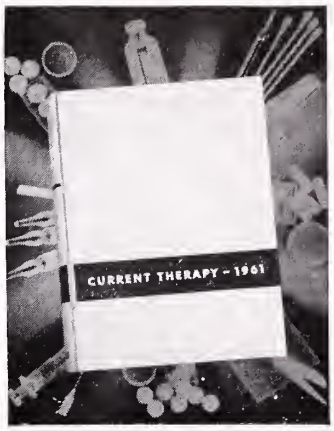
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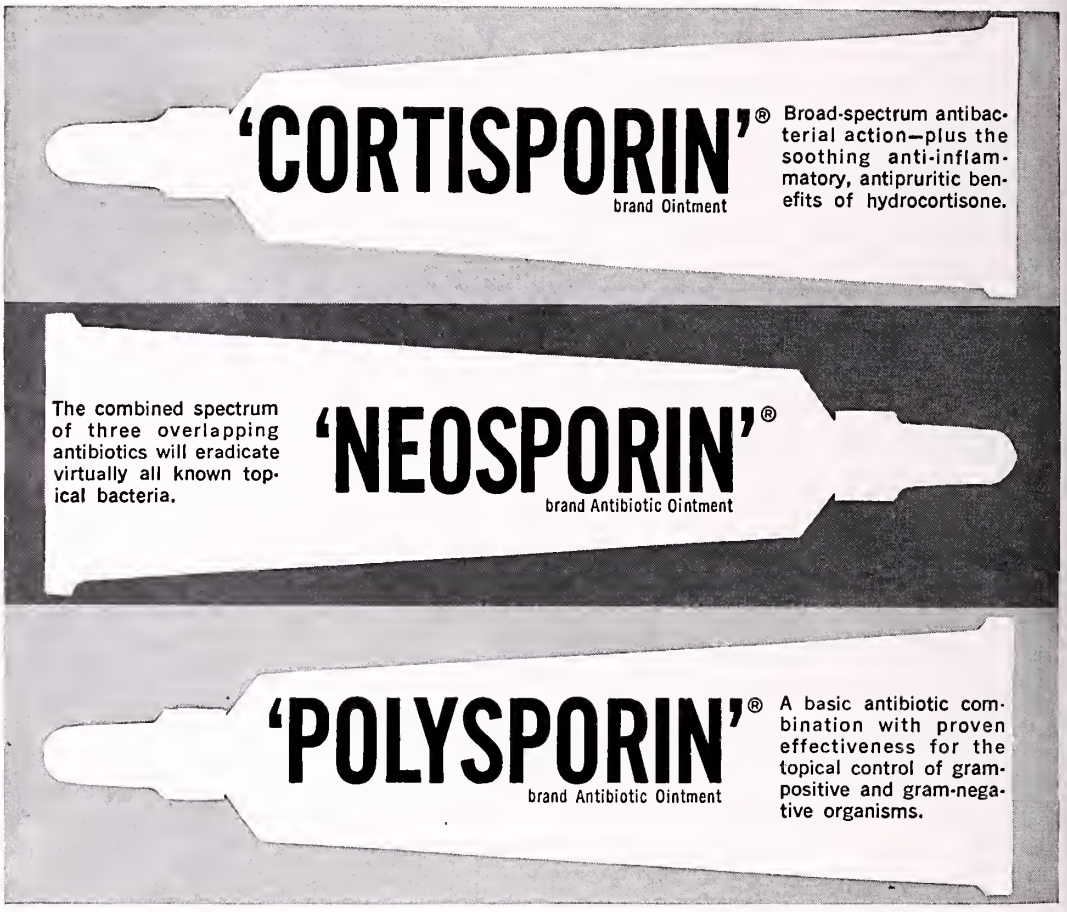
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(Continued from page 394)

as well as physicians. The author is not identified except by name.

Progress in the Treatment of Fractures and Dislocations 1950-1960

By Thomas B. Quigley, M.D., 102 pp., $2.50, W. B. Saunders Company, 1960.

An inexpensive decennial review with 426 references, by two staff members of the Peter Bent Brigham Hospital.

Progress in Neurology and Psychiatry, Volume XV

Edited by E. A. Spiegel, M.D., 619 pp., $12.75, Grune & Stratton, Inc., 1960.

Usual excellent annual review, by 59 contributors. Very careless proofreading.

Ciba Foundation Study Group No. 5, Regulation of the Inorganic Ion Content of Cells

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Cecilia M. O'Connor, B.Sc., 100 pp., $2.50, Little, Brown & Co., 1960.

The usual high quality reporting and printing—fascinating if you have the chemical and mathematical bac ground for it.

The Surgical Clinics of North America, Vol. 40, No. 6

I. S. Ravdin, M.D., guest editor, pp. 1467-1736, W. Saunders Co., December, 1960.

A symposium on recent advances in surgical resear and their clinical applications plus an additional artic on the treatment of decubitus ulcers in paraplegia.

The Medical Clinics of North America, Vol. 44, No. 6

Charles T. Lee, Jr., M.D., and Edward H. McGehe M.D., guest editors, pp. 1459-1725, W. B. Saunde Co., November, 1960.

This symposium on the office laboratory is divid into two sections; one on office procedures and the oth on screening procedures, plus a three-year cumulati index.

The Medical Clinics of North America, Vol. 45—No. 1

Herbert E. Schmitz, M.D., Guest Editor, pp. 1-232, W B. Saunders Co., January, 1961.

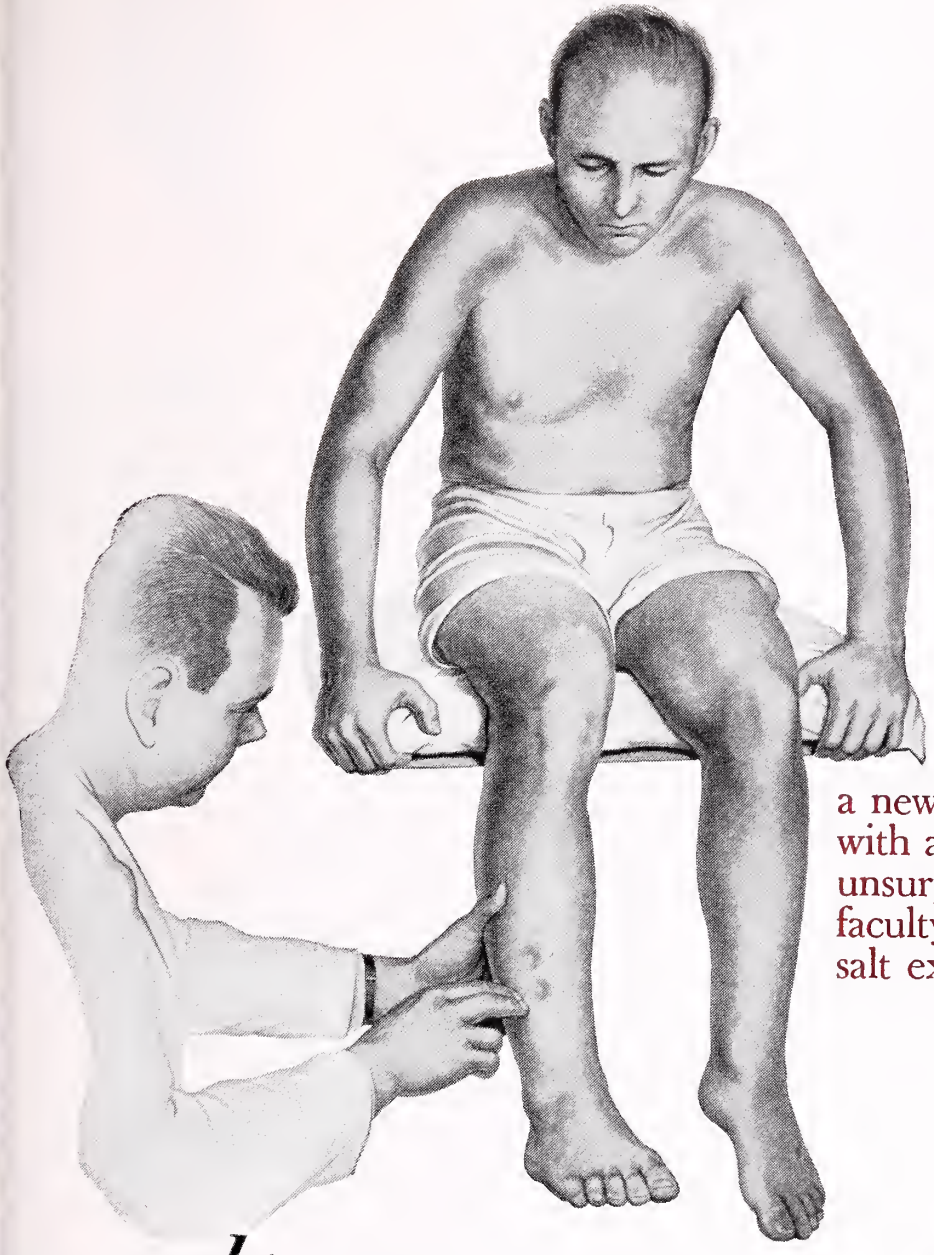
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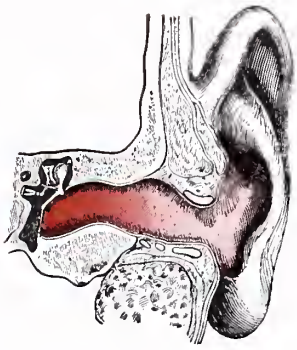
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*Pomeranze, J.: J. New York M. Coll. *1*:32, 1959.

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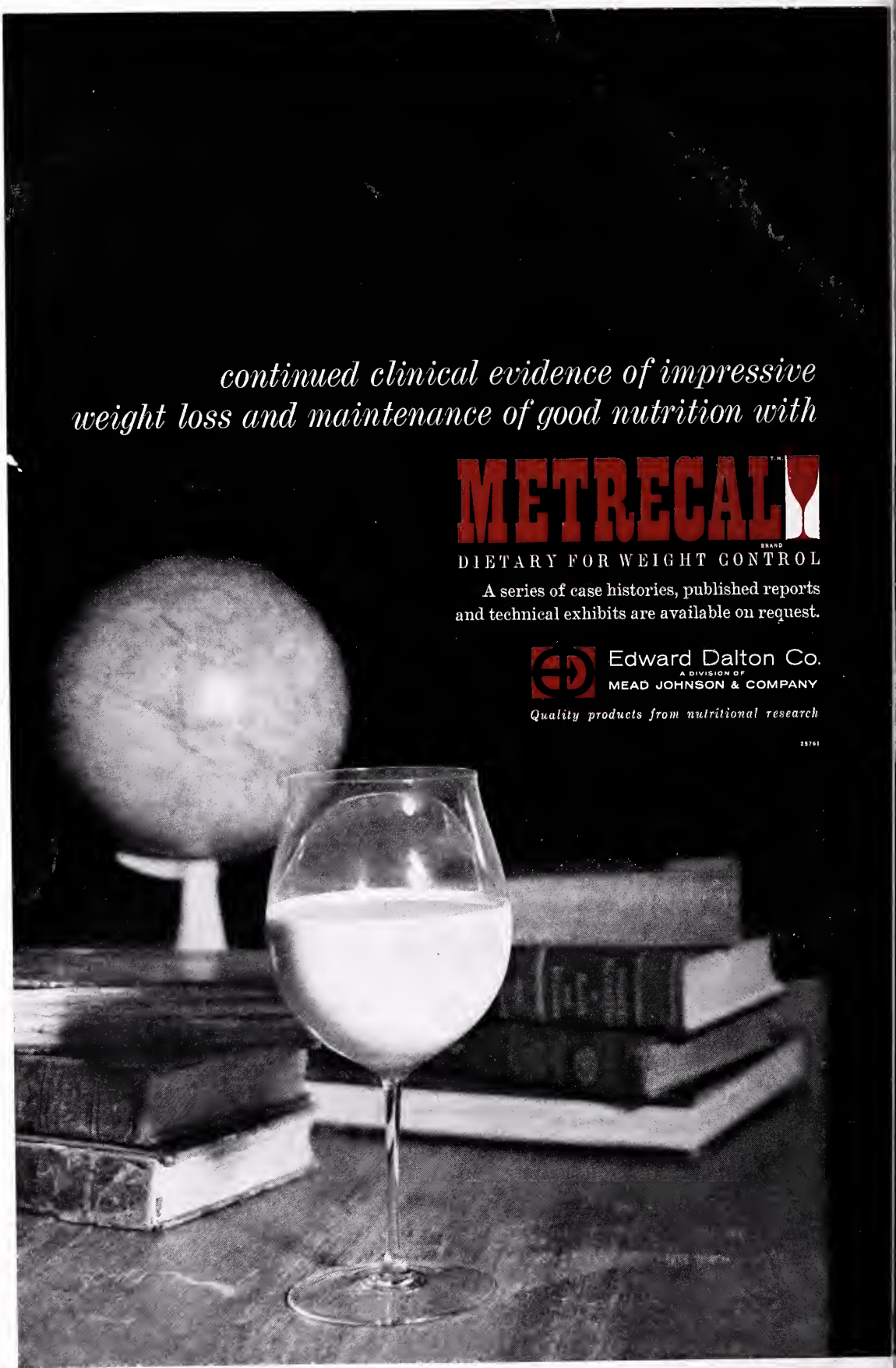
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Correspondence

EDITOR:

As an editor, I would not like to take issue with your editorial, Our Children's Keepers, in the November-December issue of your excellent journal, but as a physician of modest experience, I shall.

There seems to be little point in arguing the scientific aspects of fluoridation (I assume you meant fluoridation of public water supplies although you did not clarify the point in this editorial). As an editor, I know nothing whatever about the scientific merits or demerits of fluoridation. From what I have read it appears that I have a great deal of company in ignorance. Data have been badly misinterpreted, some have been shown to be unreliable and some writers have admitted under oath that figures used were known to have been erroneous when submitted. So much of this has gone on that I must throw up my hands, exclaiming vehemently, if vulgarly, "nobody knows from nuthin."

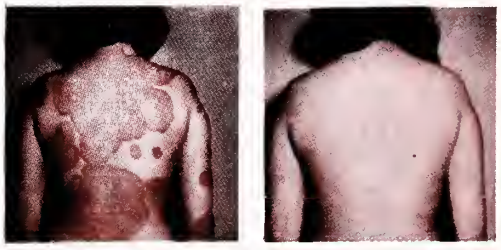
And as a physician I object to the effort to take from physicians and dentists their proper roles as advisors in matters of health. Individual health is *not* a matter of concern for government in a free society (meaning, of course, the type of republic given us by the founders of our present form of government). If it becomes so, the form of government must change to something no physician would like to see. Dosing with chemicals must *not* be done indiscriminately or on a mass basis. Definitions mean little here. You may call fluorine what you will; the simple fact of putting it in the public water supply constitutes an effort to do something to the physical structure or function of consumers of the water. I may try to do that in the practice of medicine but only on the basis of considered physical need of the individual to whom I am individually responsible. Maybe there are individuals deficient in fluorine but if so it is probably only one of many deficiencies. Do you propose to correct all of them by mass supply?

HERBERT L. HARTLEY, M.D.
Editor, *Northwest Medicine*

What is the public health, if it is not the sum of the health of individuals? If public health is a matter of concern for government—and we have long since agreed that it is—then so is individual health. The principle of prevention of preventable disease—including traffic accidents and poisoning, along with contagious diseases—is firmly established, and amply justifies the prevention of dental caries, which education and nutrition clearly cannot prevent. Fluoridated water does infinitely more good than harm, and the harm it does do is trivial. We are still for it.—ED.



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1. Welsh, A. L.: Report, Conference on the Management of Chronic Dermatoses, University of Cincinnati

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VOLUME 20
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MAY-JUNE, 1961

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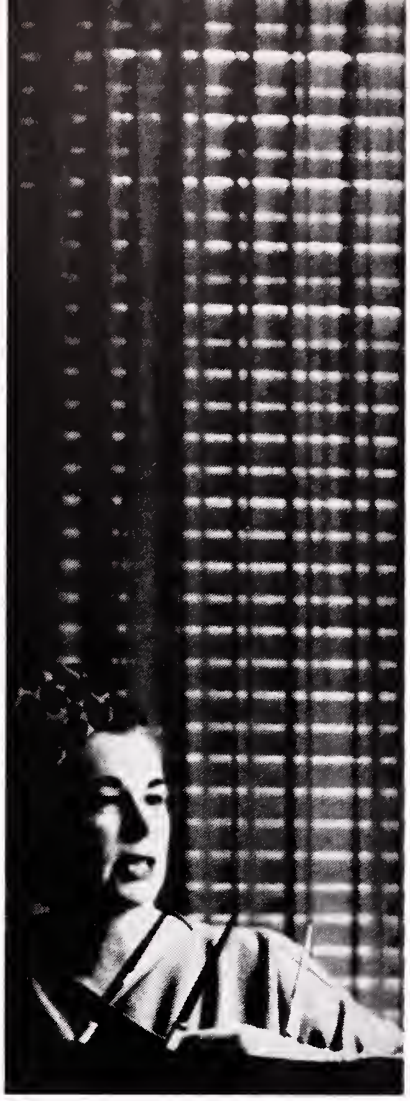
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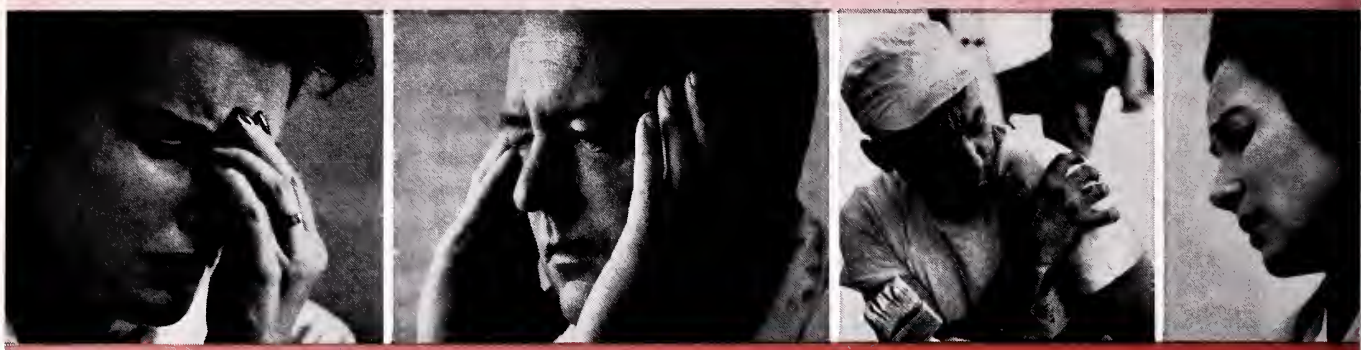
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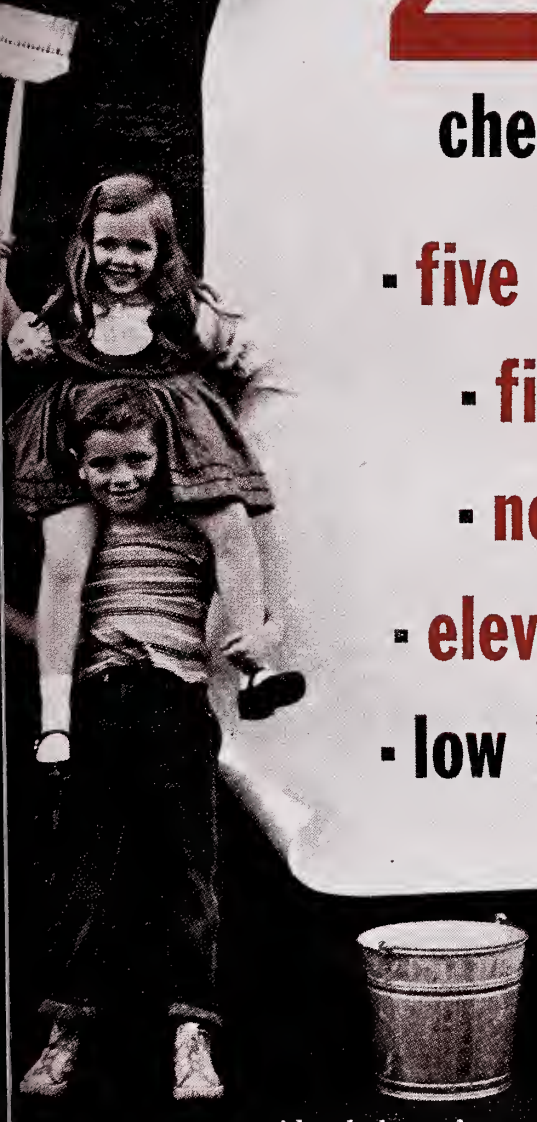
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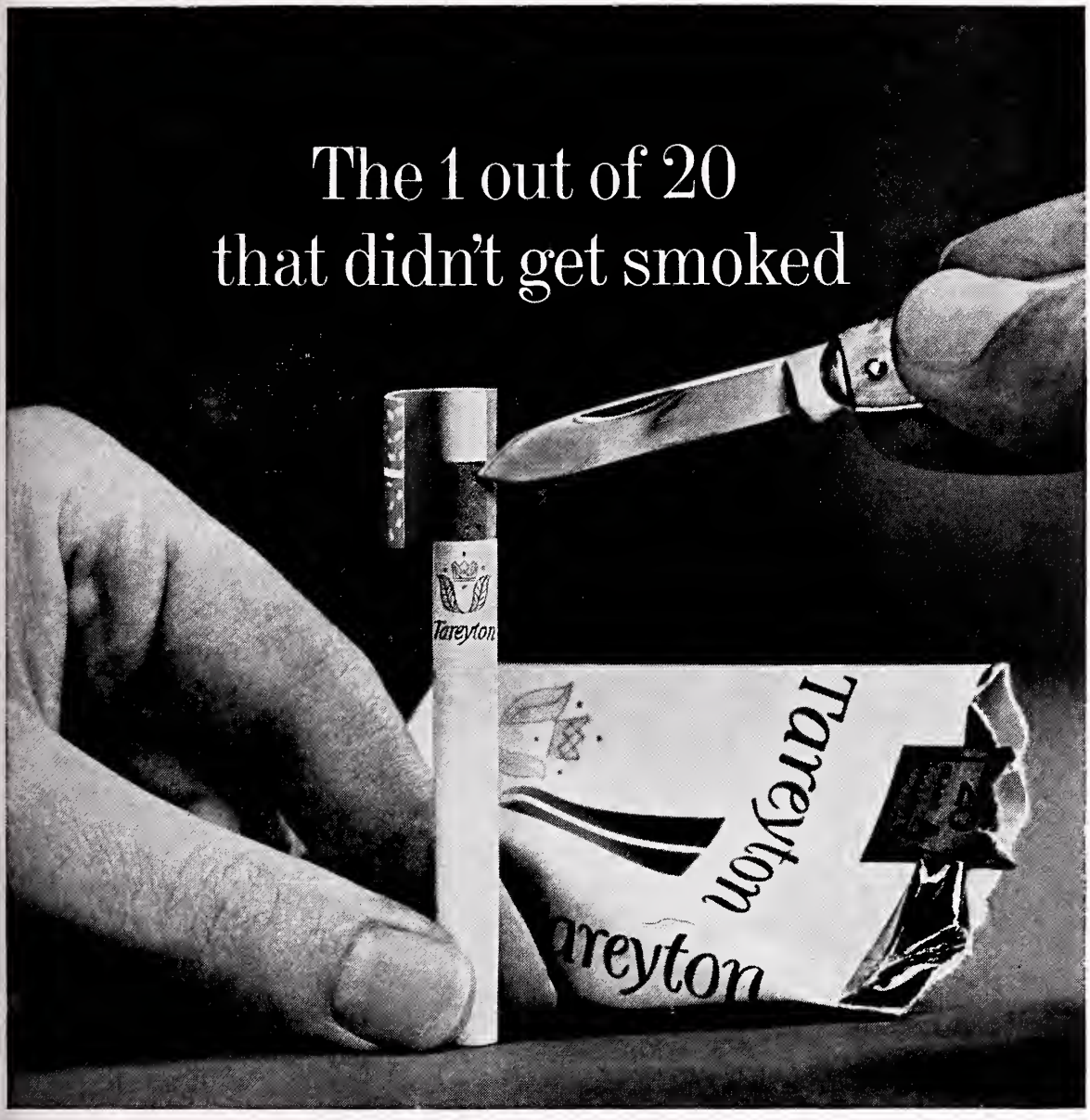


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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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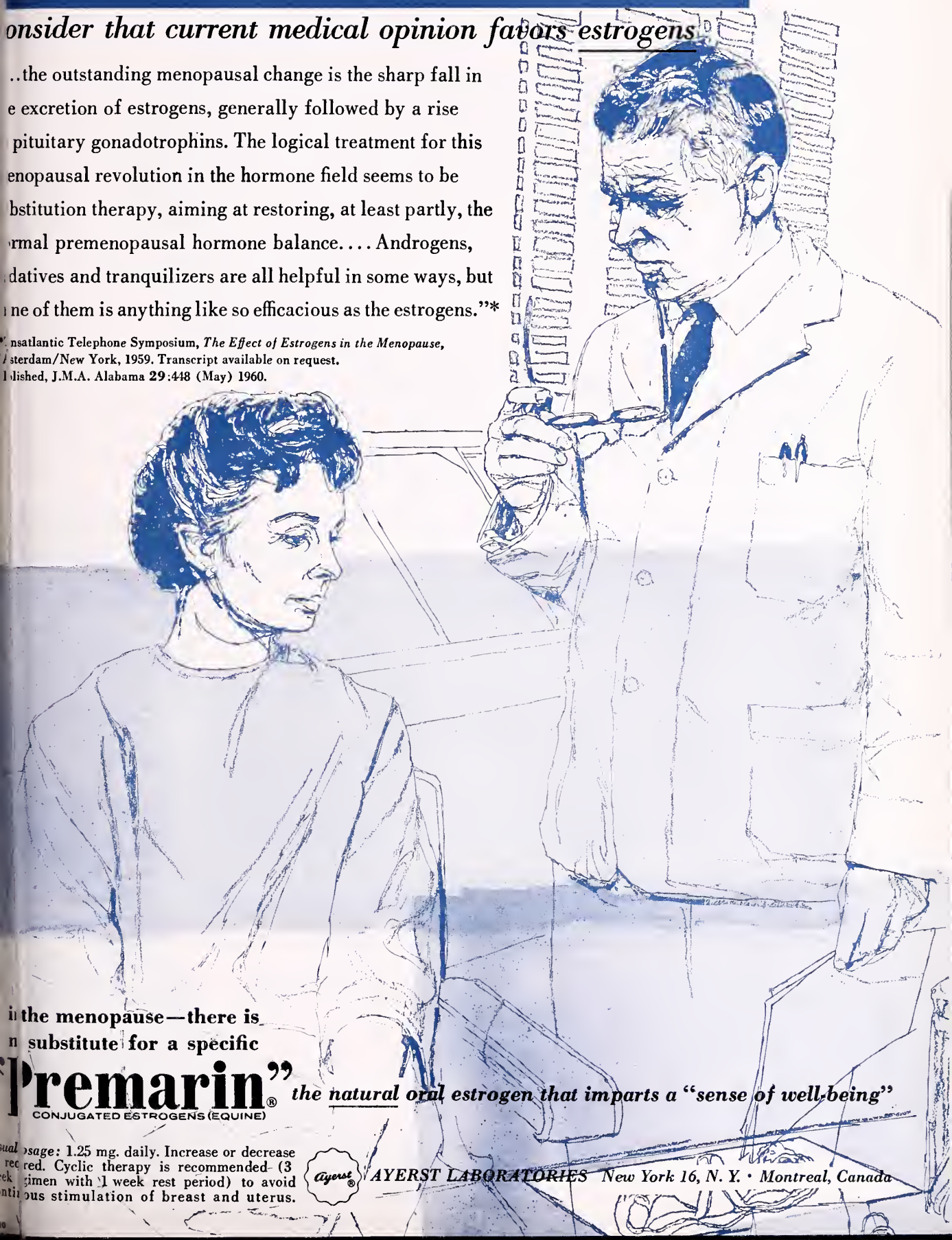
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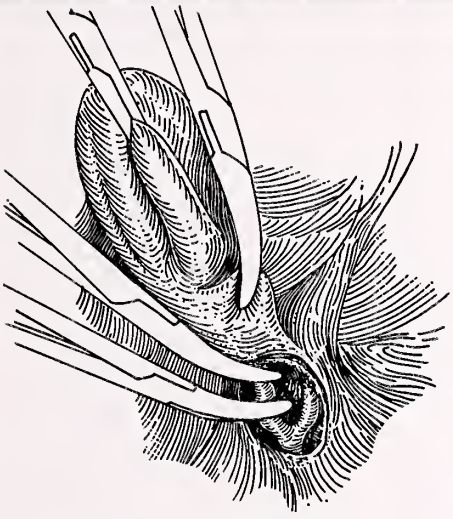
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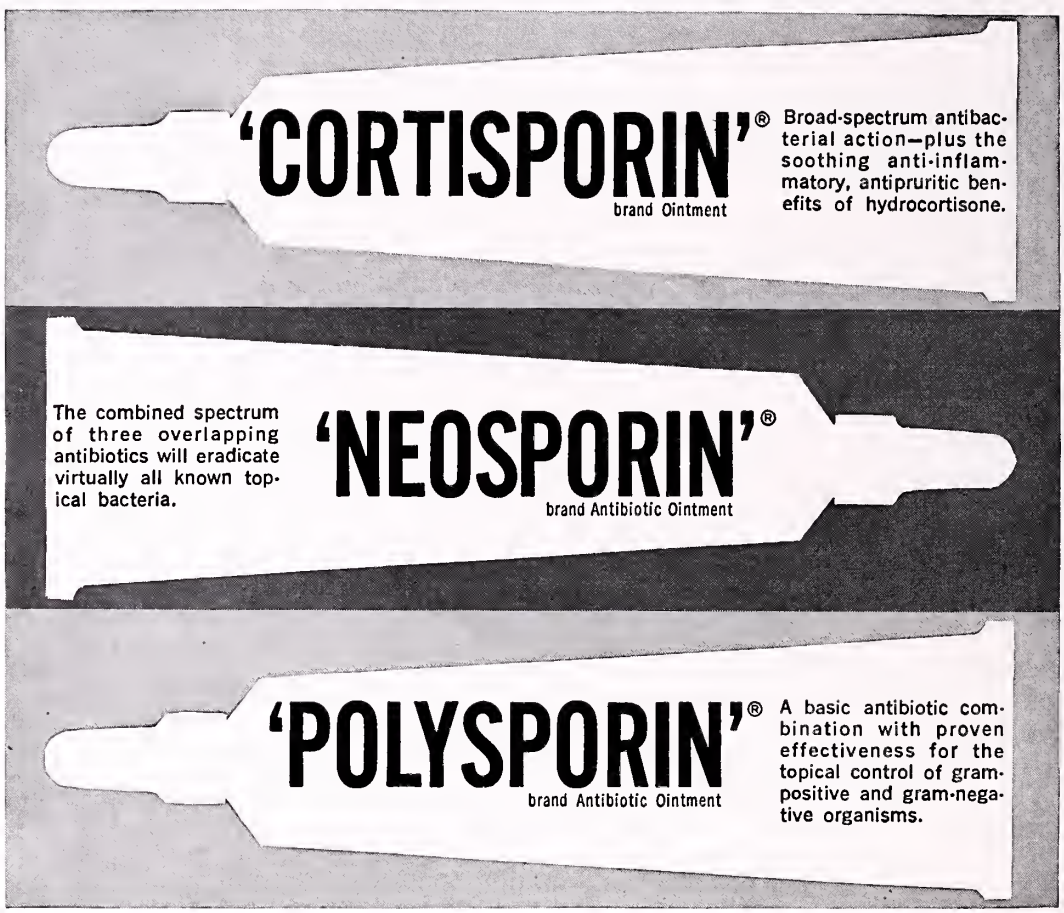
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References: 1. Lineback, M.: The Eye, Ear, Nose and Throat Monthly *39*:342 (April) 1960. 2. Fuchs, A. M. and Maurer, M. L.: New York J. Med. *59*:3060 (August 15) 1959. 3. Kreindler, L. *et al.:* Antibiotic Med. and Clin. Therapy *6*:28 (January) 1959. 4. Schiller, I. W. and Lowell, F. C.: New England J. Med. *261*:478 (September 3) 1959. 5. Edmonds, J. T.: The Laryngoscope *69*:1213 (September) 1959. 6. Horstman, H. A.: Am. Pract. & Digest Treat. *10*:96 (January) 1959.

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

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3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. In Stieglitz, E. J.: Geriatric Medicine, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

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8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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*Adams, L. D.: The Commonsense Book of Wine, New York, David McKay Company, Inc., 1958, pp. 162-163.

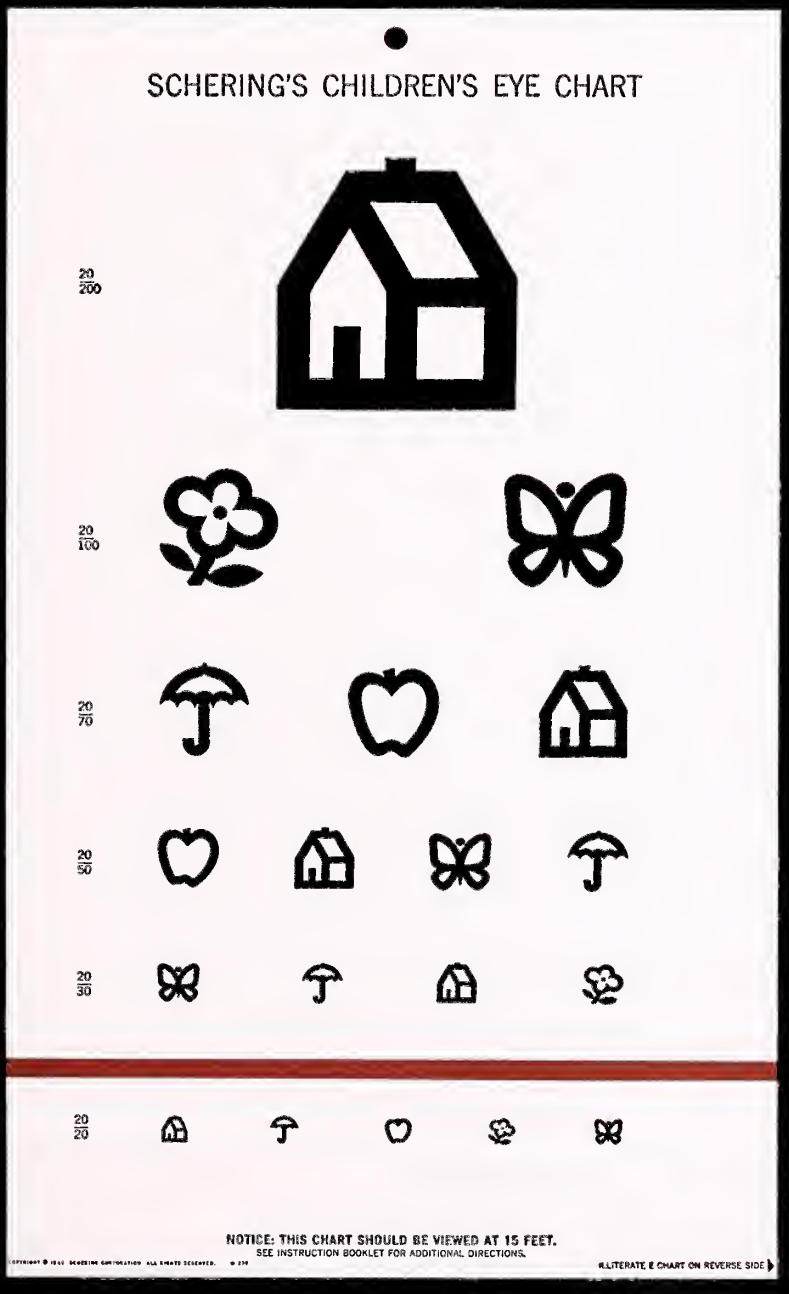
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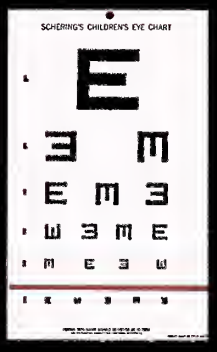
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Modern Trends in Psychiatric Therapy

CAPTAIN J. F. McMULLIN, MC, USN*

THE PROBLEMS that psychiatry seeks to solve are many and varied, and particularly so since the operational field or scope of psychiatry has become so broad and seems to be expanding in so many directions. Classically, the psychiatrist was a medical specialist in the diseases of the mind. However, in American psychiatry the trend has been to devote increasing attention and effort to problems of life stress and to the treatment and prevention of neurotic disorders.[1]



CAPT. McMULLIN

ndeed, a not unlikely extension of such a trend in he future would result in a redefinition of psyhiatry as the study of human behavior, and the sychiatrist would become the medical specialist hose work was to understand and modify human ehavior.

Most of us would deplore such a grandiose trend, implying as it might the possession of more wisdom than any of us possesses in the present state of our knowledge. A healthier trend is evident in our preoccupation with more basic questions as to the etiology of mental disorder and a redefinition of the views of different schools of thought on this subject.[2] Solutions of these basic problems related to the pathology and the treatment of mental disorder must be of paramount importance to us as physicians.

In this year of 1960 the most pressing problem in the field of psychiatric therapy remains, as for many previous years, the enormous patient load, both inpatient and outpatient. We have become too familiar with the frequently-cited statistics that out of our million-and-a-half hospital beds in the United States, about one-half are occupied by the mentally ill. It is universally agreed that mental disorders constitute our number one public health problem. Besides our more usual clinical problems, the field of psychiatry seems to have taken as its responsibility that ever-prevalent disorder, alcoholism. Add crime to this, and we enlarge our scope still further. Finally, there seems to be a trend toward the inclusion of just plain unhappiness as a disorder meriting psychiatric treatment.[3]

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The opinions in this paper are those of the author and are not cessarily those of the Department of the Navy or Department of efense.
Received for publication October 21, 1960.
[1] Whitehorn, J. C.: American psychiatry, Am. J. Psych. 114:109 ug.) 1957.

[2] Kruse, H. D., Ed.: Integrating the approaches to mental disease, Hoeber-Harper, New York, 1957.
[3] Annual Review of Medicine, Vol. 10, 1959. Annual Reviews, Inc., Palo Alto, California.

Obstacles to Psychiatric Treatment

While so much remains to be learned and applied, we must recognize the significant advances in psychiatric therapy that are in a sense products which have come about in recent years. One of the outstanding trends at present is our concern with how best to accomplish delivery of the "product" to the patient who needs it now. There are no simple answers to this, but such considerations lead us to the very pertinent questions as to some of the reasons patients do not receive psychiatric treatment. Among these I would list the following: (a) the limited availability of treatment facilities, such as clinics, hospitals, or private practitioners; (b) the persistence of a sense of stigma and other unhealthy public attitudes towards psychiatric patients; (c) the shortage of personnel in the field; (d) the cost of care, especially private care; (e) the noninclusion of psychiatric treatment in health plans like Blue Cross and Blue Shield. These and similar questions have provoked solutions that concern particularly the administrative psychiatrist, who is now achieving greater stature in his efforts to bring treatment to so many people who need it. More and more states are establishing or enlarging their departments of mental hygiene and are attracting some of our most competent psychiatrists, who work very closely with the governors of the states individually and in the annual governors' conferences to bring about better care for the mentally ill.

Trend Away From Hospitals

Hospital care of psychiatric patients has traditionally been centered in the state mental hospitals for the most part. The recent years have witnessed quite a revolutionary change in our thinking about public mental hospitals. The direction of this trend seems to be away from such hospitals and back towards more local community resources. Many leaders in psychiatry believe that the chronicity in mental illness is more a result of the social structure in psychiatric hospitals than of the illness itself, so that we recognize now the need to modify the setting and mode of care and treatment. Other leaders in American psychiatry have almost condemned the conventional mental hospital to oblivion, but the widespread acceptance of the open door program and the recent developments of research units in our mental hospitals are but two examples of the changing scene. Moreover, the development of intensive treatment programs directed toward the unrecovered patient in the mental hospital is another indication of the continuing necessity for strengthening of the mental hospital in its relationship to community psychiatry. One is repeatedly struck by the changing atmosphere of the mental hospital from that of a restrictive custodial institution to one of a rehabilitation center to which patients come voluntarily for help.

One of the most hopeful trends is the reporting of declines in patient census in more than a few states recently. It is a fact that more patients are being discharged or sent on trial visits or to the outpatient clinics. This is a by-product of the recognition of the need to shorten the inpatient phase of treatment. Of course, it is the application of modern methods of treatment that has made this possible.

It has long been recognized that because of the woeful disparity in most mental hospitals between the patients' therapeutic needs and the treatment facilities actually available, a powerful force is set up which intensifies pathological tendencies in the patient to withdraw from reality. It is not that deterioration is an inevitable outcome of psychosis; rather it well may be a manifestation of the psychotic patient's attempts to adapt to a highly traumatic environment. In an average mental hospital perpetuating psychotic mechanisms tend to render treatment more difficult and a successful outcome less likely. When, on the other hand, treatment is instituted early and carried out in the community, deterioration may be prevented and in any case rarely achieves the severity which is possible in a hospital. Even the most effectively run mental hospital fosters passive-dependent attitudes. The patient's needs are all provided for, and his day is regimented. In spite of the finest activities program, the hospital environment can never be as challenging as any ordinary day in the community. Like the phobic who must face the situation he fears, and the addict who must meet his problem without the help of drugs, so the hospitalized patient must resume extramural reality contact before truly effective psychotherapy takes place. In this sense, outpatient facilities represent logical extensions of intramural care.

Advantages of Outpatient Care

It has been estimated that fully one-fourth of all psychotic patients in this country never enter a hospital. Many are able to maintain a practical adaptation to a fortuitously well-protected home and job situation. Many more psychotic people would be able to continue in the community with the help of outpatient care. By keeping such people at work supporting their dependents, providing for the education of their children and in other ways contributing to family life, a destructive psycho-social trend can be reversed. During periods of emotional crisis, outpatient emergency care may forestall the total disorganization of adaptation, which makes hospitalization unavoidable, either by direct treatment of the patient or by easing an intolerable home situation.

Modern programs of outpatient after-care tend to liberalize the discharge policy of a hospital, making it possible to send patients home at an earlier date and keep them in remission for much longer periods of time. When outpatient facilities are available, popular prejudices tend to decrease, and people apply for treatment early in the course of mental illness, at a time when the prognosis is better. These outpatient clinics are helping to overcome the isolation of the mental hospital from the surrounding community and as a result, better liaison is maintained with the medical practitioners in the community.

Finally, the economic aspects of a good outpatient program must be mentioned. It has been estimated that the prevention of as few as two or three commitments a year would save as much money as is spent on the entire clinic budget. Similarly, a liberalized discharge policy will lead to economies.

The National Mental Health Act

In view of the forementioned facts, the enactment of the National Mental Health Act in 1946 represented a particularly wise and far-sighted contribution to the mental health of our nation. Funds available through this Act have been the most important single source for new mental health clinic facilities. Over 500 new clinics have so far been established in the United States with funds available through this Act. The intention of the Act is to provide the means for starting new clinics or for expanding old ones. Once the new facilities are well established, Federal funds are withdrawn and made similarly available to other installations. In starting a clinic, the Federal government provides half the money and expects the state and local community to provide the other half.

Implicit in the program is the hope that local governments will raise sufficient funds to run the clinic on their own once the value of such facilities has been demonstrated. It was anticipated by the framers of the Act that expanded clinic facilities would intensify existing personnel shortages. Accordingly, the Act has provided the means to meet this by providing for the training of new specialists in psychiatry, psychology, social work, nursing, and ancillary fields. In recent years, the funds available for grants in support of psychiatric training for general physicians and other physicians in practice have been exhausted early, because of the large number of such applicants. This is an encouraging sign for the future.

Day Hospitals

There is an increasing trend away from the restrictions of full-time hospital care, and the newest development along those lines is that of day hospitals. Dr. Ewen Cameron first conceived this when he came to realize that psychiatric hospitals were vastly different from general hospitals, in that mental patients do not go to bed as part of their treatment. Secondly, the average mental patient does not go to the hospital to get well, but only to get well enough to go home, where treatment continues. Thirdly, we are apt to take over the idea from general hospitals that a hospital is a place where patients and only patients are treated. Actually, we are aware that the patient is only part of the problem; we have to consider his whole setting and the family unit, so that the day hospital is an expression of the fact that the patient is not treated in bed, that he does not stay in the hospital until he is well, and that the family has to be treated as well as the patient.

In this setting, the patient comes to the hospital from 9 A.M. to 5 P.M., and throughout his stay remains in touch with his family and community. The day hospital prevents the retreat of the patient into the hospital and escape into a private room. This system does not allow him to lose touch with his problem, and he is more likely to enter into therapy which reveals what the real problem is. Of course, the somatic therapies, such as insulin or electroconvulsive therapy, are part of the therapeutic regimen when indicated. Day hospitals have been increasing, and they report that their day care units operate at $\frac{1}{3}$ to $\frac{1}{4}$ of full hospitalization costs.

The night hospital is somewhat the counterpart of the day hospital and provides a part-time therapeutic milieu for patients who can be employed during the day, either full or part time. They participate in the evening program and have the advantage of being in the group. In actual practice, it is found that night patients are closer to being outside the hospital and on their own than the day patients are. Another innovation in recent years has been the establishment of night clinics, and the Veterans Administration has pioneered in this approach. A few communities are fortunate enough to have child guidance clinics where night facilities make it possible also for fathers to enter the treatment situation.[4]

Aftercare

In spite of the universal recognition that aftercare represents the most important phase of the hospital mental treatment program, this has been administered in a haphazard way heretofore. Traditionally, the same doctors and social workers who treated the patient intramurally attempted to supervise him after he went back to the com-

[4] Lidz, T., Cornelison, A. R., Fleck, S., and Terry, D.: The intrafamilial environment of the schizophrenic patient, Psychiatry 20:329 (Nov.) 1957.

munity. This was wasteful for several reasons. An aftercare clinic rarely maintained a regular staff, but rather had a staff of different people from different hospitals on different days. The best modern practice in this category utilizes a group of independent aftercare clinics set up in the geographical area in which professional services are actually to be dispensed, making it possible for patients and their families to enjoy psychiatric supervision of unprecedented continuity and intensity right in the community where the patient resides.

Inasmuch as most relapses and returns to mental hospitals occur within the first three months after discharge, it is the plan of the aftercare clinic to give support of maximum intensity during this period, tapering off thereafter as the patient's condition permits. Previously, patients were routinely placed on convalescent status for one year and discharged after that time if they were still in the community. In keeping with the new program of individualized aftercare, patients are now placed on convalescent status indeterminately. This can be prolonged or terminated at the discretion of the clinic team. This is an experiment of major importance in modern psychiatry.

In the field of the private practice of psychiatry, a definite trend in treatment practices is evident. Gone is the day when private practice psychiatrists confined their efforts to those who among all their patients perhaps needed them the least. Today a good half of the practice of any general psychiatrist is made up of people so seriously disturbed that short-term hospitalization, if not mandatory, is certainly desirable. Even if this can be avoided, some other form of supportive therapy, in addition to the essential psychotherapy, is indicated, perhaps in the setting of a clinic, day or night hospital, vocational rehabilitation program, sheltered workshop, or other community agency.

Family Care of Patients

While on the subject of care of the mental patient outside the hospital, we note a strong trend toward the use of foster-home placement for such adult patients. It is only in recent years that in this country we have begun to appreciate how valuable this type of care is. This system had its start in Belgium, in the town of Gheel, where among some 25,000 people, there are about 2,600 patients in family care, or about one in every ten persons. This type of care is designed not only for the convalescent patient, but also for the chronic patient in whom a permanent emotional disability is expected.

Through the work of Lidz[4] and others, we now better appreciate the role of the family in the causation of breakdown. As a by-product we have come to use the term schizophrenogenic mother to express this causation succinctly if not too accurately. In any event, all too frequently, family stresses which broke down the patient's emotional adaptation in the first place cannot be eliminated, and to return the already traumatized patient to that unfortunate situation for convalescence is to court relapse. At times, an overprotective environment can be even more disorganizing in its effect than an overtly rejecting one, generating unreasoning resentment in the patient who is fighting desperately for emotional independence. Moreover, many patients simply have no home to which they can return.

Family care is a major part of total treatment in some European countries. In Norway, as an example, 39 per cent of the committed mentally ill patients are in private family care under supervision of a mental hospital or the state. In the United States, an increasing number of the states, and the Federal Government as well, are using family care for patients. The Veterans Administration in 1957 placed 730 patients in family care, but in 1958 such placements jumped to 1,249 for the year.

Psychopharmacology

With the many new drugs being made available, the therapeutic mood continues eager and enthusiastic. In our work with the so-called tranquillizers, we find that they have given psychiatry an unexpected by-product by forcing us to improve our methods of treatment. These drugs exposed on a large scale the important influence through suggestion of new medicines which may also have powerful pharmacological properties. The firm establishment of the pharmacological efficacy of these drugs has required carefully controlled studies. In the literature on psychopharmacology, accounts of soundly planned and executed research have almost entirely displaced the impressionistic reports based on "experience" which used to fill the pages of psychiatric journals.[5] Although tranquillizing drugs are now second only to the broad spectrum antibiotics in dollar sales and number of prescriptions written, most of the voluminous clinical literature regarding them consists of reports of trials and impressions. With the introduction of ever-increasing numbers of tranquillizers and combinations of tranquillizing drugs the flurry of clinical appraisals, which is now in its fifth year, is bound to continue. Sound studies and organized efforts such as the 1956 conference on the evaluation of pharmacotherapy in mental illness, which was sponsored by the American Psychiatric Association and the National Institute of

[5] Stevenson, I.: The challenge of results in psychotherapy, Am. J. Psych. 116:120 (Aug.) 1959.

Mental Health, are like beacons to guide us through the confusion and chaos.

At the present time, clinical trials proceed in abundance on a group of drugs called anti-depressives. These seem to fall into two groups. First, there is the amine oxidase inhibitor group —the hydrazines—like iproniazid (Marsilid), its successor, Marplan and a host of similarly acting drugs of varying potency and effectiveness. Second, there are those of the promazine group, essentially phenothiazines, like imipramine (Tofranil). All these are still in the process of evaluation, and we must guard against premature enthusiasm.

What of the other somatic therapies? Insulin treatment has flourished for nearly 20 years, but its hazards, expense, and the failure of its empiricism to withstand critical inspection seem to have all but resulted in its demise in the past two years.[6] However, the Second International Conference on Insulin Treatment, held recently in New York City, raised the question—has insulin treatment been outmoded? The critical consensus was that it has not, and its value in the treatment of schizophrenia has repeatedly been confirmed.

Psychosurgery, which reached its peak about ten years ago, is nearly obliterated, and only its staunchest advocates see any prospects for its continued use as a therapy in psychiatry.

As for electroconvulsive therapy, the indications for its use have been persistently re-evaluated so that it is clearly indicated for at least symptomatic alleviation of certain forms of depression and for certain schizophrenic reactions.

The inhalation of carbon dioxide, as proposed some years back by Meduna, has now had rather adequate clinical trials, but this form of treatment —used principally for the psychoneuroses—is now used only by a relatively few dedicated adherents, so that its use seems to be generally on the wane.

The Therapeutic Community

Perhaps the most exciting development associated with the sociological approach is the refocus on the concept of the milieu as a therapeutic agent. Incorporating concepts contributed by sociology are the social therapeutic clubs, half-way houses, day hospitals, night hospitals, and hospital therapeutic communities, all of which may be said to be examples of social psychiatry in action. Probably a greater number of such units has been established in this country during the past year than in the preceding eight years combined. Convinced that "upgrading" of patients could be achieved by social manipulation within the hospital setting, one group of workers has directed intensive efforts of the same general type to rehabilitation in the community. Their preliminary experiences show that such a program has had a noticeable reciprocal impact on the hospital structure with a differential effect on the various traditional role groups. Psychiatrists and social workers appear threatened by the new emphasis, while nurses and occupational and industrial therapists have enjoyed a re-enforcement of their status.

Social treatment, as it is practiced in the United States today, had its rebirth in the past decade or so in England. In viewing some of the interesting innovations which British psychiatrists have been carrying out in the general area of social psychiatry, we note an emphasis on the open door policy and giving the patients increasing responsibilities for the direction of their daily activities. These modifications play important parts in the remarkable change in hospital atmosphere. The surrender of the key by the staff, and the termination of dealing with problems by authoritarian measures, such as seclusion, restraint, and transfer to a disturbed ward, have resulted in different staff-patient attitudes.

In such a setting, problems are now resolved by changes in personal relations between patients and staff. Experience has shown that the unlocking of chronic wards does not result in any increase in elopements. However, such a situation demands a well-developed program of occupational therapy and activities for several months prior to opening the wards. As to the deteriorated and confused chronic schizophrenics, it might well be that they never would have reached that stage had they spent their hospital life on an open ward, since removal of all contacts with the outer world is very likely a principal cause of their "deterioration."

When we study the social processes in the first of the therapeutic communities established by Dr. Maxwell Jones at Belmont Hospital in England, we see how an experimental form of organization, aimed at "democratizing" the authority system, has evolved in the attempt to resolve the problem of avoiding coercive authority in patient-therapist relationships in a hospital setting where considerable centralization of authority is necessary for hospital administration alone. The desirable features as well as the hazards of their model for authority are discussed and compared by Stanton and Schwartz in their recent book, *The Mental Hospital.*

Perhaps the most intensive and extensive study and descriptions of a therapeutic community in the United States is that by Captain Harry Wilmer, of a psychiatric ward at the U. S. Naval Hospital, Oakland, California. Even though it was a locked admission ward where patients were kept no

[6] Bourne, H.: Insulin coma in decline, Am. J. Psych. 114:1015 (May) 1958.

longer than ten days and the goal was primarily patient management, their experience serves as a most illuminating example of problems faced, methods of meeting them, and the results obtained through the establishment of therapeutic community concepts.

He points out that the basic departure of the therapeutic community concept from traditionally established concepts of the mental hospital is the emphasis that it places upon socio-environmental factors in the patient's hospital experience. In the hospital which operates as a therapeutic community, socialization and the sense of belonging take their place along with psychotherapy. The traditional order of hierarchy is reversed, and the hospital is regarded as the patient's world rather than the doctor's domain. Thus, the traditional staff attitudes and staff-patient relationships are considerably altered. So also are the procedures employed: self-control, dignity, and trust supplant excessive imposed controls, restrictions, regimentation, and tradition-bound rituals.

Evaluation of the efficacy of therapeutic communities will undoubtedly prove to be a difficult task, but it already seems to have demonstrated its value in patient management. It seems probable that therapeutic community care will be found to be of significantly greater value than current standard hospital care. The therapeutic community concept will make a deep imprint in the future practice of medicine.

Residential Care for Children

Progress is slow in providing sufficient inpatient facilities for disturbed children. Provision for such remains a most pressing need in the majority of the United States. A hopeful sign is the progress being made in one of our smallest states, Delaware, where there has been established a network of day centers for severely retarded children whose I.Q.'s are 35 or less and whose ages run from 3 to 21. Since June, 1957, when the legislation was passed, four such centers have been established throughout the state. They now serve 41 patients, are operated by the renowned Dr. Tarumianz, and the centers are supervised by an educator, assisted by a nurse, psychologist, consulting endocrinologist, social worker, and training aides. Patients are taken to the center by bus at 9 A.M. and returned home at 3 P.M. Club activities, toilet training, cleanliness, self-feeding, etc., make up the curriculum. Twenty-six of the children so far have responded well to the program. Eleven have shown moderate improvement. The other five have not shown much progress. In addition, the Delaware Department of Instruction provides special classes throughout the state for educable (I.Q. 50-85) or trainable retarded—in the 35-50 I.Q. group.

Other evident trends in child psychiatry are noted in that there are fewer children in our epileptic state colonies, because of newer drug treatment and better community attitudes. As recently as ten years ago, New York Public Schools suspended any epileptic child. Now, these children are referred to suitable clinics and on medical recommendation continue to attend school, their disability unrecognized by other children.

Psychiatric Treatment Under the Health Plans

In a discussion of the problem of bringing psychiatric therapy to those who need it, I would be remiss if I did not discuss how the modern health insurance plans facilitate or inhibit access to treatment.[7] More than 70 per cent of Americans and Canadians are now covered by health insurance plans. Often excluded from these benefits is the one group of disorders that disables the largest number of people. Mental illness fills 50 per cent of all hospital beds. Most general practitioners say that a third of their office patients come because of emotional problems. Yet, a charge for treating a disorder correctly labelled psychiatric will usually be turned down by the staff of a prepaid plan. The public's general indifference to this exclusion of coverage can be attributed to the fact that almost no one expects ever to be mentally ill. Efforts continue to be exerted by the American Psychiatric Association to get some adequate form of coverage for psychiatric disorders made a part of insurance and health plans, like Blue Shield and Blue Cross. An increasing number of state plans provide from 15 to 30 days hospital care for such cases, the majority of which are treated in general hospitals or sanitaria—rarely, if ever, in a state institution. Few of us read the fine print in our health plans or in our insurance policies so a few figures and facts might be enlightening. Plans like the Kaiser Foundation Health Plans sell their clients low-cost psychiatric service as a separate item. Others, like Group Health Association of Washington, D. C., have a counseling program on a similar basis. At least one plan, the St. Louis Labor Health Institute, includes in its plan fairly extensive psychiatric service, which its outpatient clinic supplies. More and more union contracts are demanding and more industrial and business firms are providing for outpatient as well as inpatient psychiatric care as an added fringe benefit.

According to a recent survey,[8] some 30 per cent of the Blue Cross plans extend benefits for mental

[7] McKerracher, D. G.: Modern psychiatry and the health plans, New Eng. J. Med. 260:10 (Mar. 5) 1959.
[8] Reed, L. S.: Health insurance coverage for mental illness, Pub. Health Rep. 73:185 (Feb.) 1958.
[9] Linn, L.: Handbook of Hospital Psychiatry, International Universities Press, 1955.

cases in general hospitals with the same coverage as is provided for general illness. The remainder extend less or no coverage. As of January, 1957, 51 of 80 Blue Cross plans provided some coverage for alcoholism, 54 for drug addiction, and 74 for self-inflicted injuries. Benefits are usually drastically reduced if the emotional illness is treated in a mental institution. Blue Cross coverage has made definite progress when one considers that a decade ago, only 5 of the 81 plans extended benefits for mental illness up to 31 days in a general hospital. As to Blue Shield, only 33 of the 64 plans cover mental and nervous illness on the same basis as all other conditions. Thirty-nine of those plans extend coverage for alcoholism, 42 for drug addiction, 43 for nervous and mental conditions, and 54 for self-inflicted injury. As to the commercial plans, the coverage is somewhat better for the most part. Much study and effort goes on in search of ways to provide good psychiatric coverage under these plans, since all hands realize that a tremendous number of emotional illnesses and neurotic disorders especially are being treated under other diagnoses.

If we look clearly at today's psychiatric picture, we see that people now seek care of a general-hospital standard, at least for their own mentally sick relatives. This explains the popularity of the psychiatric wards in general hospitals. Since governments usually respond to public opinion, they have increased the funds for psychiatric services and research. All this reflects a new attitude towards psychiatry. Many forces have contributed to this change. The war showed the prevalence of mental disorder. The increase in the number of old people has resulted in more senile psychosis. Mental health education of the public by private and public agencies has broadened knowledge of psychiatry and made more people come closer to realizing that they too could become mentally sick.

The modern approach shifts the focus of psychiatry from the large institution toward the community. This new approach requires better facilities. Uncertainties about causes and treatment do not excuse degraded surroundings. The World Health Organization has created committees to study existing psychiatric services. Its reports have aroused much interest and triggered many changes. Likewise, hospital inspection agencies like the Joint Commission on the Accreditation of Hospitals and the American Psychiatric Association's Mental Hospital Inspection Service have been quietly performing signal services in the field to improve the level and quality of care in our mental hospitals, public as well as private.

Thus, the modern approach to psychiatric therapy rejects the huge chronic hospital with its rate of $3.00 per diem or less, its stigma, and its locked doors. Instead the modern approach emphasizes smaller treatment facilities with easier availability, adequate therapy, comprehensive rehabilitation and, above all, good communication between the treatment groups and the community.

Psychiatry a Century and a Half Ago

A physician should treat his deranged patients with respect, and with all the ceremonies which are due to their former rank and habits of living. Carpets upon the floors of their rooms or cells, curtains to their beds, taste in the preparation and manner of serving their meals, will all serve to prevent distress and irritation, from a supposed change in their condition in life. I have known a deranged gentleman complain of being addressed without the title of Mr.; and I have seen several others turn with an indignant look from their food, when served to them upon a table not covered with a cloth, or in vessels they had not been accustomed to in their own families. With this habitual attachment to forms in behaviour, and taste in living, there is in this class of patients a similar respect for former habits of society, for which reason they should always eat, sit, and partake of amusements, by themselves. The great advantage which private madhouses have over public hospitals is derived chiefly from their conforming to this principle in human nature; which the highest grade of madness is seldom able to eradicate.

BENJAMIN RUSH, M.D.
Medical Inquiries & Observations Upon the Diseases of the Mind.
Philadelphia, Richardson, 1812, p. 179.

Fluke infestation from freshwater fish is uncommon in Hawaii and affects principally Hawaiians and Filipinos

Internal Parasites of Man in Hawaii

With Special Reference to Heterophyid Flukes*

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IMMIGRATION of various racial groups to the Hawaiian Islands, especially from Asia, has resulted in the introduction of parasites which may have established themselves here due to the mild and temperate climate, suitable hosts, or sanitary and food habits of the people. Introduced plants and animals may establish and perpetuate parasitic life cycles by serving as objects of encystment or as intermediate hosts. Certain food habits, such as the eating of raw fish, have been retained and popularized in the islands.



DR. CHING

The present study, suggested to the writer by Dr. J. E. Alicata, was to determine the present status of local parasitic infections which may have resulted from the presence of the above importations. Published data on the incidence of parasitic infections in man in Hawaii are limited to a few papers,[1] though local annual reports of the Department of Health indicate the existence of amoebas, flagellates, ascarids, trichurids, hookworms, pinworms, and tapeworms.

In this study, special effort was made to determine the incidence of heterophyid flukes in the population, since various reports[2] have indicated the possible health hazards of these parasites, which are acquired from eating raw infected fish, especially mullet. Therefore, emphasis was placed on the sampling of persons of racial groups known to be fond of raw fish.

Methods and Materials

Stool specimens were obtained from the following sources: hospitals, health centers and clinics, private physicians, and the State Department of Health Laboratories. Except for 185 samples from Hilo, Hawaii, 1,195 samples were obtained from persons living in Honolulu or surrounding areas from September, 1959, to August, 1960. Specimens from persons of Hawaiian or Filipino descent were requested, although random sampling of the rest of the population was attempted.

Fecal material was received from the Department of Health laboratories in 10 cc vials, and from other sources in waxed half-pint paper cartons. A single specimen was received from each person although additional specimens were used in questionable cases. Wet mounts were made as soon as specimens were received in the laboratory. The formalin-ether concentration technique by Ritchie[3] was employed for every stool specimen. Wheatley's trichrome method was used for permanently stained preparations of amoebas. Iodine and a protozoan dye were employed for temporary staining of slide material.

Data such as sex, age, racial ancestry, place of birth, length of residency in Hawaii, and occupation were recorded on punch cards.

Results and Discussion

The total incidence of protozoans and helminths from 1,380 persons is 12.25 per cent. Since only one stool specimen was examined in the majority of cases, the incidence is probably much higher

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[1] Of 133 human diaphragms examined at random at autopsy in Honolulu, 7.4% harbored trichinae larvae. Alicata, J. E.: Parasites and parasitic diseases of domestic animals in the Hawaiian Islands, Pac. Sci. 1:69-84 (Apr.) 1947.
Alicata, J. E., and Kartman, A. Y.: Incidence of oxyuriasis among a group of school children in Honolulu, HAW. MED. J. 7:214-215 (Jan.-Feb.) 1948.
Powers, D. F.: A worm study of Maui Agricultural Company's Hamakuapoko Camp, Plantation Health Bull. 1:6-11 (Jan.) 1937.

[2] Alicata, J. E., and Schattenburg, O. L.: A case of intestinal heterophyidiasis in man in Hawaii, J.A.M.A. 100:1100 (Apr.) 1938.
Glover, M. A., and Alicata, J. E.: Intestinal heterophyidiasis, HAW. MED. J. 16:636-639 (July-Aug.) 1957.
Martin, W. E.: The life histories of some Hawaiian heterophyid trematodes, J. Parasit. 44:305-323 (June) 1958.

[3] Brooke, M. M.: Amebiasis. Methods in laboratory diagnosis, U. S. Dept. of Health, Ed., Wel. Comm. Dis. Center, Atlanta, Ga., 67 p., 1958.

TABLE 1.—*Parasites and Commensals Found in 1,380 Persons in Hawaii*

PARASITE OR COMMENSAL	NUMBER OF INFECTIONS	PER CENT INCIDENCE	PARASITE OR COMMENSAL	NUMBER OF INFECTIONS	PER CENT INCIDENCE
Heterophyids	41	2.98	Trichostrongylus sp	1	0.07
Clonorchis sinensis	15	1.09	Hookworm	8	0.58
Opisthorchis sp	1	0.07	Enterobius vermicularis	8	0.58
Taenia sp	6	0.43	Entamoeba histolytica	4	0.29
Hymenolepis nana	1	0.07	E. hartmanni	2	0.14
Ascaris lumbricoides	13	0.94	E. coli	27	1.96
Trichuris trichiura	28	2.03	Endolimax nana	11	0.80
Trichurid	1	0.07	Dientamoeba fragilis	5	0.36
Strongyloides stercoralis	16	1.16	Trichomonas hominis	1	0.07
			Giardia lamblia	14	1.01

Total Infections: 203
Multiple Infections: 27
Individuals Infected: 169 or 12.25%

than is indicated. Results are summarized in Table 1. The incidence of infection as indicated is quite low and reflects in general the good sanitary conditions, high economic level, and adequate nutrition of people in the cities of Honolulu and Hilo. A survey of rural areas as such would probably yield a higher rate of infection. Powers[1] examined 1,009 persons for worm ova and found 32.9 per cent to be infected in the Hamakuapoko camp in Maui. Persons were chiefly adult laborers of Filipino, Japanese, or Portuguese ancestry. Parasitic infections will be discussed in detail.

Heterophyids are intestinal flukes, the infective larval forms of which are found in muscles of mullet and the gills of freshwater fishes in Hawaii. The greatest number of infections, 41 (3 per cent), belonged to this group. Table 2 summarizes the racial ancestry of those infected and the degree of infection.

Infections were rated arbitrarily as light, meaning 1-5 eggs per coverslip; medium, 6-10; heavy, 11 eggs and over, with the concentration of material on the slides being the same throughout.

The majority of infections occurred in persons of Filipino and part-Hawaiian or Hawaiian ancestries. The incidence of infection of heterophyids of the two groups together is 7.6 per cent. It appears that other raw-fish-eating groups, such as those of Japanese and Chinese ancestries, are seldom infected. It was not determined if immigrant Filipinos became infected here or in the Philippines, where heterophyids have been reported from man.[4] In the Philippines, Africa and his associates have recovered heterophyid eggs from such organs as the brain, spinal cord, and heart. In the heart the ova were said to produce lesions, cardiac symptoms, and often heart failure.

Every one of the 15 cases of infestation by the Chinese liver fluke, Clonorchis sinensis, was of Chinese ancestry, either a resident of the islands who had visited China, or a native of China now residing in the islands. In some cases, the last trip to the Orient had occurred five to ten years ago, but the persons still showed ova in the stools. Binford[5] reported four cases of C. sinensis in three part-Hawaiians and one Korean who had never left the islands. He attributed the infections to importations of frozen, pickled, or salted fish from the Orient or infections of native fish. In his paper, however, the species of fluke shown in the microphotograph of the eggs is not conclusive. The characteristic opercular rim of C. sinensis eggs is not visible in two of the three eggs shown. The third egg appears to have a rim. Comparison of the egg of Ascaris lumbricoides and the eggs of C. sinensis as photographed in his paper with actual egg measurements and other microphoto-

[4] Africa, C. M., de Leon, W., and Garcia, E. Y.: Visceral complications in intestinal heterophyidiasis of man, Acta Medica Phil. 132 p., Manila (June) 1940.
[5] Binford, C. H.: Clonorchiasis in Hawaii, Public Health Repts. 49:602-604, 1934.

TABLE 2.—*Heterophyid Infections*

ANCESTRY	NUMBER EXAMINED	NUMBER INFECTED	PER CENT INFECTED	LIGHT	MEDIUM	HEAVY
Filipino	207	15	7.2	4	7	4
Hawaiian or Part Hawaiian	303	24	7.9	7	9	8
Chinese	129	1	> 0.1	1	0	0
Japanese	338	1	> 0.1	1	0	0
Other groups	403	0	0.0	0	0	0
Total	1,380	41	2.98 (average)	13	16	12

graphs indicates that the trematode eggs are much smaller than C. sinensis eggs, and more similar to heterophyid eggs. The range for C. sinensis eggs is 27-35 by 12-20 μ; the range for Stellantchasmus falcatus, the common heterophyid in mullet, is 20-24 by 10-11 μ.

Of the six persons infected with tapeworm, four were of Filipino ancestry and two were part-Hawaiians. Price[6] found that 110 of 126 cases of Taenia saginata infestation at The Queen's Hospital were of Filipino ancestry.

Seven dual infections of A. lumbricoides and T. trichiura were detected. In fact, a total of 15 infections of whipworms and another parasite or commensal were found. At least half of the whipworm infections were found in people born away from the islands. Two infections of T. trichiura consisted of eggs with embryos. Since T. trichiura eggs usually require two to three weeks for development in the external environment, the presence of embryonated eggs in freshly-passed stools is unusual. One other trichurid infection was found upon stool examination of a 51-year-old Filipino male living in downtown Honolulu. The eggs measured 70-80 by 30-42 μ in length and were embryonated. In size, the eggs resemble those of T. ovis or T. globulosa which are found in ruminants. Upon second and third examinations four and six weeks later, no eggs were found in the stools.

S. stercoralis infections were found in the following groups: Japanese, 3; Caucasian, 5; Filipino, 7; and others, 1. Eight of these persons were born in the Orient or had spent some time in the Orient. Hookworm infections were scattered among four racial groups, Caucasian, 2; Filipino, 2; Part-Hawaiian, 3; Chinese, 1; with three persons not born in the islands.

No specific test for pinworms was conducted in this survey; those cases reported from stool specimens do not reflect the occurrence of pinworms in the community. Alicata and Kartman[2] examined 138 children ranging from 2½ to 7 years of age by the NIH anal swab method and found 31.1 per cent to be positive for pinworms upon two examinations. Infections were commoner in Caucasians, 40 per cent than in Orientals, 21 per cent.

The rates of amebic infection seem extremely low. Only four infections of E. histolytica were found. E. hartmanni, formerly considered as a small variant of E. histolytica, is now considered as a distinct species and was identified according to criteria set by Burrows.[7] The incidence is 0.29 per cent for E. histolytica in comparison to a range of 0.17 to 0.38 per cent by Kuntz[8] for 1953-1957 and 2.9 per cent by Brown and Garber[9] for military personnel. Kuntz indicated a downward trend of protozoa[1] infestation which he thought might be due to the use of antibiotics as well as improved sanitary conditions. Iodamoeba bütschlii and Chilomastix mesnili were not found in any survey stool specimens, although the latter was observed in stool specimens from patients at the Hawaii State Hospital at Kaneohe.

Single infections of Trichomonas hominis, Hymenolepis nana, Opisthorchis sp., and Trichostrongylus sp. were recorded. According to Hall,[10] H. nana was the common human tapeworm in the

[6] Price, A. S.: Beef tapeworm in Filipinos, Haw. Med. J. 5:334 (July-Aug.) 1946.

TABLE 3.—*Correlation of Data with Incidence of Parasites and Commensal Protozoa in 1,380 Persons*

	NUMBER EXAMINED	NUMBER INFECTED	PER CENT INFECTED
1. Sex			
a. Male	796	109	13.69
b. Female	584	60	10.27
2. Birthplace			
a. Hawaii	982	101	10.28
b. Mainland	114	8	7.01
c. Orient	216	54	25.00
d. Others	68	6	8.80
3. Age in Years			
a. 0-5	198	10	5.0
b. 6-15	129	19	14.7
c. 16-25	139	19	13.7
d. 26-35	226	26	11.5
e. 36-45	228	28	12.3
f. 46-60	281	44	21.9
g. 60+	179	23	12.8
4. Racial Ancestry			
a. Japanese	338	17	5.0
b. Caucasian	279	24	8.6
c. Filipino	207	38	18.3
d. Chinese	129	21	16.3
e. Hawaiian or Part-Hawaiian	303	52	17.2
f. Cosmopolitan	54	8	14.8
g. Others	70	9	12.8
5. Occupation			
a. Pre-school	194	9	4.6
b. Student	161	20	12.4
c. Clerical and Sales	45	3	6.7
d. Housewife	240	32	13.3
e. Professional or Managerial	118	12	10.2
f. Skilled or Unskilled	241	32	13.3
g. Retired	77	8	10.4
h. Unemployed	81	20	24.7
i. Food Handlers	114	20	17.5
j. Others	109	13	11.9

[7] Burrows, R. B.: Morphological differentiation of Entamoeba hartmanni and E. polecki from E. histolytica, Am. J. Trop. Med. Hyg. 8(5):583-589 (Sept.) 1959.

[8] Kuntz, R. E.: Intestinal protozoans and helminths in U. S. military and allied personnel, Navy Hospital, Bethesda, Maryland, Am. J. Trop. Med. Hyg. 8(5):561-564 (Sept.) 1959.

[9] Brown, R. L., and Garber, M. J.: Prevalence of intestinal protozoa in adults at four military bases in California, Am. J. Trop. Med. Hyg. 9:262-264 (May) 1960.

[10] Hall, M. C.: Problems of parasitism in Hawaii, Rev. de Parasit., Clin. y Lab. 2:367-383 (May-June) 1936.

islands, although he did not give actual figures. Powers[3] reported nine cases or 0.8 per cent of 1,009 plantations laborers positive for H. nana. The Trichostrongylus and Opisthorchis infections were, respectively, from a student recently from Korea and a 72-year-old man born in Japan, and were most probably acquired in the Orient. Trichostrongylus is a parasite of cattle, and Opisthorchis of dogs which have eaten raw infected fish.

Although ova of Fasciola gigantica, cattle liver fluke, were not found in this survey, cases of fascioliasis do occur in the islands.[11] As Stemmerman pointed out, man is not a natural host and most liver flukes in humans are not fertile. Ova are not likely to be recovered from fecal examinations.

Table 3 summarizes data obtained from each person and the distribution of parasites and commensal protozoa. Men appeared to have a slightly greater incidence of parasites than women. Those born in the Orient have a high rate of infection, double that of those born in Hawaii.

The question of residence in Hawaii was intended to distinguish recent immigrants from those who had lived here at least seven years or half their lives. In many cases, the time was an estimated one taken from sources other than the patient himself. Generally, one can state that persons recently from places like the Philippines, Japan, China, and Korea have higher rates of parasitic infection than persons living in the islands.

In the age groups, those 46 to 60 years old had the highest rate of infection, 21.9 per cent. The racial ancestry, heterophyid infection and birthplace of 44 in this group are compared:

ANCESTRY		HETEROPHYIDS	ORIENT-BORN
Filipino	18	7	17
Hawaiian	10	9	0
Caucasian	6	0	0
Japanese	4	1	1
Chinese	4	1	2
Others	2	0	1
	44	18	21

Over half of this age group was composed of Filipinos born in the Philippines or Hawaiians and Part-Hawaiians, and these were most commonly infected with heterophyids.

Infection with heterophyids accounts for the high incidence in Filipinos and Hawaiians as reported in Table 2. Almost half of the infections in each of these two groups is due to heterophyids. There are low rates of infection for those of Japanese and Chinese descent. Infections with Clonorchis sinensis accounted for 15 of the 21 infections in the Chinese.

[11] Alicata, J. E.: Human fascioliasis in the Hawaiian Islands, Haw. Med. J. 12:196-201 (Jan.-Feb.) 1953.
Stemmermann, G. N.: Human infestation with Fasciola gigantica, Am. J. Path. 29(4):731-759 (July-Aug.) 1953.

In the occupational groups, the unemployed and food handlers seem to have the highest rates of infection. The category of food handlers was created because of the number of them that submitted stools for routine bacterial testing to the Department of Health. This included a number of cooks from China. Again, there seems to be a correlation as to their racial ancestry and eating habits. Taken together they show the following characteristics:

ANCESTRY		AGE		PARASITES	
Japanese	2	16-25	6	Heterophyids	11
Chinese	13	26-35	6	C. sinensis	7
Filipino	16	36-45	6	T. trichiura	5
Hawaiian	8	46-60	15	E. coli	5
Others	1	61+	7	S. stercoralis	4
				Others	14
	40		40		46

Summary

Of 1,380 stool specimens received from persons in Honolulu and Hilo, 169 or 12.25 per cent were positive for parasites and commensal protozoans. The incidence of infection was found to be low for worms and pathogenic protozoa, reflecting the high economic level, good sanitation, and adequate nutrition of the people. Immigrants from the Orient accounted for at least one-third of the number of parasitic infections, so that the rate of infection for parasites acquired locally would be even lower.

Food habits of certain groups resulted in the largest number of parasites reported, that of heterophyid flukes which may be acquired by eating raw mullet or other fresh water fishes. Those infected were mainly of part-Hawaiian, Hawaiian, and Filipino ancestries. Cases of Clonorchis sinensis, the Chinese liver fluke, were of Oriental and not local origin. Other parasitic infections are discussed.

Persons born in the Orient, in the age groups 46 to 60, and unemployed or employed as food handlers, appeared to have the highest rates of parasitic infection.

Acknowledgments

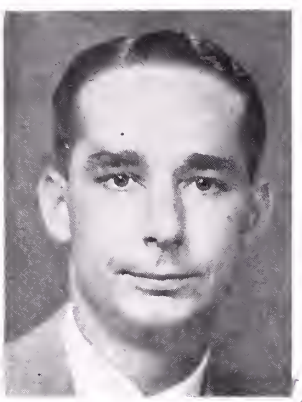
It would be difficult to thank every individual who helped me in connection with the survey work. To Dr. J. E. Alicata goes my appreciation for advice and suggestions in the preparation of this manuscript. The following organizations and individuals aided in the collection of stool specimens: State Department of Health Laboratories, G. Ching; Bureau of Epidemiology, R. Onouye; Kuakini Hospital, S. Chinen; St. Francis Hospital, Dr. S. Lazo, J. Muraki; The Queen's Hospital, Dr. M. Brault, Dr. W. H. Civin; Maluhia Hospital, Dr. R. Hiroshige; Kaiser Foundation Hospital, Dr. J. Bennett, J. Yano; Children's Hospital, Dr. J. Hanley; Hilo Hospital, T. B. Vance, A. Mantabayat; Hilo Department of Health Laboratory, H. Minette, M. Shimizu; and Kailua Medical Laboratory, H. Hill.

Radioiodine will control hyperthyroidism in almost all patients, and do it safely, economically, and painlessly.

Radioiodine Therapy of Hyperthyroidism

ROBERT G. RIGLER, M.D., ROBERT A. NORDYKE, M.D., and FRED I. GILBERT, JR., M.D.,* Honolulu

THE GOAL OF treatment in hyperthyroidism is to produce a euthyroid state as rapidly and as economically as possible without hazard to the patient. It is inevitable that certain questions arise regarding any newer therapeutic approach to any disease. The following are questions commonly encountered regarding the use of radioiodine:



Bauer

DR. RIGLER

QUESTION: How does radioiodine compare to surgery in the treatment of hyperthyroidism?

ANSWER: With either surgery or radioiodine approximately 95 per cent of patients will have their hyperthyroidism brought under control within three months. Radioiodine therapy results in no mortality, laryngeal nerve paralysis, hypoparathyroidism, or scar.

QUESTION: How are patients selected for radioiodine or surgical therapy?

ANSWER: The patient's age, the size and nodularity of the gland, the avidity of the gland for I^{131}, previous thyroidectomy, the presence of certain conditions such as pregnancy, cardiovascular disease, mental disturbances, and sensitivity to antithyroid drugs are some of the factors which help determine the method of treatment.

QUESTION: Does hyperthyroidism appear more frequently in some races than others?

ANSWER: Perhaps. (See Fig. 2.)

QUESTION: Will irradiation from I^{131} injure the patient or cause cancer?

ANSWER: No. Radioiodine is concentrated almost exclusively by the thyroid and the remainder rapidly excreted through the urine. After almost 20 years of clinical use in over 150,000 persons, there have been no reports of thyroid adenocarcinoma after I^{131} therapy.

Four-Year Series

From December, 1955, to December, 1959, 63 patients with hyperthyroidism received therapeutic doses of radioiodine and have been followed for a minimum of eight months. Concurrently, 43 patients with hyperthyroidism were treated surgically by subtotal thyroidectomy. This represents 106 persons with thyrotoxicosis treated at the Straub Clinic during this four-year period.

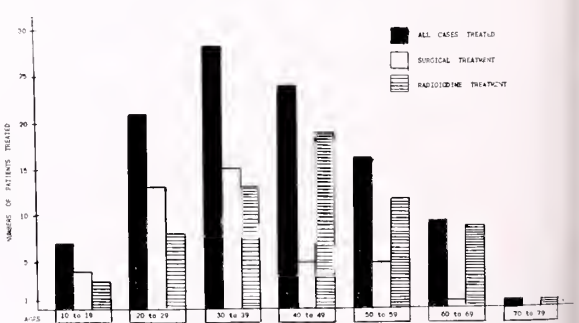


FIG. 1.—*Age distribution of 106 treated cases of hyperthyroidism, Straub Clinic, Dec. 1955 to Dec. 1959.*

* From the Departments of Radiology (Dr. Rigler), Nuclear Medicine (Dr. Nordyke), and Internal Medicine (Dr. Gilbert), Straub Clinic.

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Age and Sex

Ages of patients treated with radioiodine averaged 43 years, while those undergoing surgery averaged 33.5 years. The youngest patient was 13 years and the oldest 72 years. There were 32 males and 74 females which is less than the usual four to one ratio. The age distribution is indicated by Figure 1.

Racial Patterns and Incidence

We have surveyed the racial patterns in this group for various reasons. It has been repeatedly stated by senior practitioners in this community (for years alert to the diagnosis of hyperthyroidism) that a case of thyrotoxicosis in Hawaii was a rarity 30 to 40 years ago. An explanation for this impression may be that in the present era of mutual sharing of medical experiences in dealing with a particular disease through hospital and clinical conferences, a doctor becomes aware of more cases than would have been seen in isolated practice several decades ago. An additional factor is the increased usage of more sensitive laboratory tests which can detect the incipient stages long before the disease reaches the classical proportions of exophthalmos, hyperactivity and a goiter which enable the diagnosis to be made from across the street.

The proportions of ethnic groups composing our population are constantly fluctuating and changing with each ten-year census. If the incidence of thyrotoxicosis is really increasing, it is important to know if this increase is shared equally by all races or confined to certain ethnic groups. Exogenous factors may play a vital role in precipitating hyperthyroidism in genetically-labeled latent cases.

The racial distribution is indicated in Figure 2. We found the occurrence of hyperthyroidism in patients of Japanese and Chinese extraction greater than would be expected from either the general population census or the probable racial incidence of patients seen by us. However, unmeasurable selection factors may be producing a bias which is difficult to assess. Certainly, a search for causative factors deserves greater emphasis in Hawaii.

Diagnostic Methods

In almost every case, the diagnosis was established by clinical examination combined with 24-hour radioiodine thyroidal uptake and protein bound iodine. A BMR, blood cholesterol, and urine creatine were sometimes utilized by the clinician to confirm the diagnosis. A surprising number of obese patients with atypical hyperthyroidism were encountered in the series, attesting to the diagnostic keenness of referring physicians throughout Hawaii. During the four-year study and follow-up period, 619 I^{131} diagnostic thyroid tracers were done.

Calculation of Dose

The size of the gland, usually estimated independently by two examiners, and the 24-hour radioiodine uptake by the thyroid were the important factors in calculating the dose. The following formula was used:

$$\frac{\text{wt. thyroid (gm)} \times \text{desired concentration of } I^{131}\text{/gm thyroid}}{\%\ 24 \text{ hour uptake}} = \text{Total dose (mc)}$$

Example: $\frac{20 \text{ gm thyroid} \times 0.15 \text{ mc/gm}}{50\%} = 6.0 \text{ mc}$

The calculated dose was occasionally shaded down

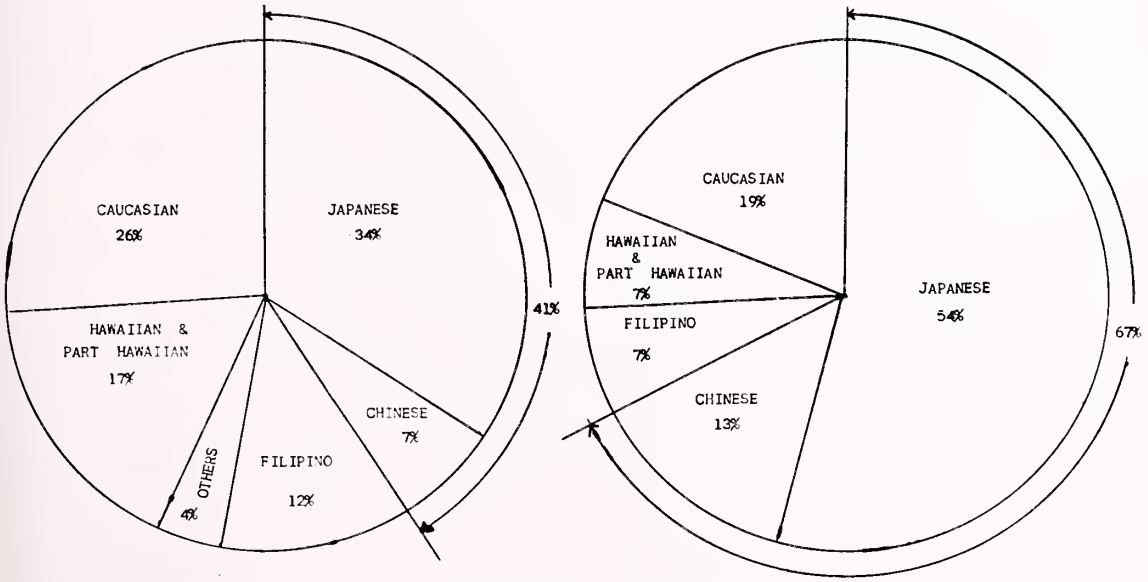


FIG. 2.—*(Left) Racial distribution of population of Hawaii, average of 1950 and 1960 censuses; (right) Racial distribution of 106 treated cases of hyperthyroidism.*

a bit for a young adult, child, or an obese hyperthyroid patient. The dose was sometimes increased above the calculated level when the patient was old, and especially if some condition such as thyrotoxic heart disease existed, making it urgent to gain complete control of the disease with a single dose of radioiodine. Using this schedule, the initial dose ranged from 2.75 to 13.9 mc and averaged 6.06 mc. The estimated dose per unit mass of thyroid varied from .075 to .22 mc per gram of thyroid tissue.

Office Procedure

After the dose has been calculated, the patient drinks the tasteless radioiodine cocktail without previous fasting. The patient is advised at the time of treatment that he will notice little or no improvement for the first month. Mild daytime sedation is usually helpful until a therapeutic effect is achieved. Between the third and fourth weeks post-treatment, he will begin to notice improvement and by the end of the second month will usually feel well. We also advise the patient of the calculated risk of hypothyroidism as well as the possible need of a second therapeutic dose of radioiodine.

In a certain number of patients (14 per cent in our series), there exists a phase of hypothyroidism that becomes evident around the third or fourth month. Only time can tell whether this is actually transient or permanent hypothyroidism. We do not necessarily advocate replacement thyroid therapy at this time unless the patient has fairly severe symptoms of hypothyroidism. At six months post-treatment, the radioiodine uptake and protein bound iodine are repeated. If the patient is clinically euthyroid and these values are normal or approximately so, the patient is then followed clinically as needed. Repeat thyroid uptake and PBI studies are done only if there is some clinical evidence of hypo- or hyper-thyroidism.

Results

Euthyroidism was achieved in 56 patients, or 89 per cent, of cases treated. Fifty-two patients, or 83 per cent, had their hyperthyroidism controlled with a single dose of radioiodine. Nine patients required two doses of radioiodine before the disease was completely controlled. Two recent patients are still not controlled and will be retreated. There were no complications of radioiodine therapy except for hypothyroidism. Five patients in this group (8 per cent) developed persistent hypothyroidism requiring replacement thyroid medication indefinitely. The average dose in these five hypothyroid patients was 5.8 mc (range 2.75 mc to 7.78 mc) and no larger than the series average (6.06 mc).

Discussion

The treatment of hyperthyroidism with radioiodine has become an accepted standard procedure. In our experience over the past four years, I^{131} therapy has been simple and effective.

The only adverse effect is hypothyroidism, which is a small unavoidable and unpredictable risk. In six large reported series totalling 1,998 cases[1] the combined incidence of permanent hypothyroidism was 9.1 per cent (range 6.5 per cent to 14.8 per cent). Our series contained 8 per cent of such cases. An additional group of patients has transient hypothyroidism which usually appears in the third or fourth month after treatment and which may last as long as six months before spontaneously resuming a normal thyroid state.

Conclusions

1. The results of this series parallel and compare favorably with other published series.

2. At the time of this writing, 61 of 63 patients treated, or 97 per cent, are clinically well from a thyroid standpoint. Two patients have persistent disease which will require re-treatment. Five patients are taking thyroid extract. A completely euthyroid state was achieved in 56 patients, or 89 per cent.

3. Five of our patients, or 8 per cent, became permanently hypothyroid, and 11 patients, or 17.5 per cent, required an additional therapeutic dose. Radioiodine therapy causes permanent hypothyroidism in about 9 per cent of patients treated, for unknown reasons.

4. The higher incidence of hyperthyroidism among patients of Japanese and Chinese ancestry in our series above the general population may be significant and needs further study.

5. Hyperthyroidism can be controlled with reliance, economy, and safety, and without pain, by radioiodine.

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The "cingulus" (belt) of shingles may occur in some unusual sites.

Zoster Facialis

A Case Report

JOHN R. CLARK, M.D.,* Honolulu

HERPES ZOSTER involving cranial nerves has been reported sporadically for a century.[1] The syndrome of auricular herpes with or without deafness, tinnitus, vertigo, and facial nerve paralysis was placed in four categories by J. Ramsey Hunt[2]: namely;

1. Herpes oticus without neurologic signs;
2. Herpes oticus with facial palsy (present case);
3. Herpes oticus with facial palsy and hypacousis; and
4. Herpes oticus with facial palsy and Meniere's disease.

Case Presentation

History. A fourteen-year-old Filipino schoolboy was admitted because of facial eruption. He had been in good health until ten days prior to admission when he had soreness of his tongue and inner cheek on the left side. In the following days a vesicular eruption occurred on the left side of his face and in his mouth. The lesions were painful three days prior to admission, and the patient presented because of mouth pain when eating.

Past History. This included varicella at age four with no recent known exposure. He had been studied for asymptomatic heart murmur and for painless hematuria of unknown origin. Circumcision was his only operation (six months prior to admission), and no allergies were known.

Physical Examination. The patient was a well-developed boy with malaise and dehydration. Over the left pinna, cheeck, chin, buccal mucosa, and tongue there was a crusting, weeping, vesicular eruption. The tongue showed a marked white coating, and the breath was fetid. Left cervical lymph nodes were large and slightly tender; there was no other significant adenopathy.

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Neurologic examination showed involvement of the trigeminal and facial nerves, all the remaining cranial nerves being tested with care. There was no loss of taste to sugar, salt, or coffee. There was excessive lacrimation on the left. Trigeminal testing revealed a poor corneal reflex on the left, skin hyperesthesia to touch, but skin hypesthesia to temperature and vibration. Facial nerve involvement was exhibited with left lid lag, decreased forehead wrinkling, and facial weakness on smiling. The left side of the face was swollen compared with the right. There was no weakness of the masticatory muscles. He had no generalized skin eruption. Deep tendon and superficial reflexes were generally hypoactive.



DR. CLARK

The remainder of the examination was essentially negative. All of the above findings became more pronounced the third hospital day.

Laboratory data were as follows: 4,700 leukocytes with 70% neutrophiles. Normal urinalysis was noted. Lumbar puncture showed a pressure of 160 to 130 mm (opening and closing) with clear fluid containing 220 WBC/mm^3, 96% being lymphocytes. Pandy test was negative, glucose and protein were normal.

Serum proteins totaled 8.0 grams per 100 cc with albumin 4.8 and globulin 3.2 grams per 100 cc, gamma globulin being 1.85 grams per 100 cc. Serum electrophoresis showed albumin 49.1%, alpha 1 albumin 4.1%, alpha 2 albumin 11.9%, beta globulins 10.4%, and gamma globulins 24.5%. Tissue cultures were attempted for identification of viruses from the cerebrospinal fluid, and vesicle and pharyngeal scrapings, and serologic study of the blood for antiviral antibodies was

performed, but these techniques gave no definitive information after two months.

Therapy consisted of supportive measures, penicillin for the adenopathy, and vitamin B-12 1000 mcg intramusularly three times at two-week intervals.

The eruption gradually subsided over the next three weeks. The facial weakness decreased with no facial swelling by four weeks, and symmetry of appearance and function was regained by eight weeks.

Discussion

Widely documented is the dermotropic and neurotropic nature of zoster. It is less certain that is caused by a virus, and that the virus might be similar or identical to the varicella virus.[3] While zoster is not rare in children, the association with lasting nerve injury is infrequent. The case presented bears out the observation of childhood zoster having mild neuralgia compared with zoster pain in adults.

This case demonstrates the incomplete involvement of cranial nerves five and seven:

The trigeminal nerve (mandibular branch) involvement produced transient minor sensory changes of the cheek. The herpetic lesion occured where the nerve innervated the pinna, external auditory meatus, temporal and cheek areas, chin, lips, mouth mucosa, and anterior two-thirds of the tongue, with a sharp delimitation to the left side of the latter (Fig. 1). Masticatory muscle function was intact, hence this motor branch of the trigeminal nerve was little or not at all involved.

Facial nerve damage was shown by the peripheral facial paralysis (Fig. 2), and the excessive lacrimation (a parasympathetic process). Because of no decrease of taste it is assumed that the chorda tympani branch of the seventh (facial) nerve was intact.

Despite the leukocytosis and lymphocytosis of the cerebrospinal fluid, there were no signs of meningeal irritation. Such a subclinical involvement of the central nervous system is common with zoster involving cranial nerves, as well as with other viral illnesses.

The failure to sustain viral tissue cultures with specimens from the varied sources might be accounted for by the lateness after onset of the illness at which the virus-procurements were attempted.

Serum protein studies showed no significant changes in globulins, the slight elevation of gamma globulin being consistent with infection.

Therapy directed against the infection is mainly supportive and aimed at preservation of integument and nerve supply. Of the varied suggestions for the neuropathy,[4] the course of vitamin B_{12} was empirically carried out; its efficacy was not proved.

Summary

A fourteen-year-old Filipino boy with a left facial eruption and left facial weakness is presented as having one of the four variants of the Ramsey Hunt syndrome. His vesicular lesion with Bell's palsy subsided after supportive therapy (Fig. 3), complete remission being seen within ten weeks of the onset of symptoms.

Acknowledgments

The assistance of Dr. Carl C. Fischer, Chief, Dept. of Pediatrics, Hahnemann Medical College and Hospital of Philadelphia; and Dr. W. Harold Civin, Pathologist, The Queen's Hospital, in the preparation of this report is gratefully acknowledged.

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The President's Page



DR. CUSHNIE

This is most likely the last letter I will write for you at least in this capacity—many problems which have been mentioned in previous letters are still under process so no firm answer can be given.

The problems in the last month have increased medically-wise because of the Legislature being in session. It appears that for all the problems we have tried to solve through enacting legislation, there have been more that we have had to fight to keep out of the statutes. It has become a problem of negative legislation—so to speak—the way we have had to fight to keep things out, including Amendments that are more detrimental to the profession than the good the original bill would have done.

A good example of this is the Medical Practice Act in regard to foreign medical school graduates. I think most of us have no quarrel with allowing the qualified in if they pass the examinations and fulfill certain requirements of residence in American hospitals, at least do what our own doctors have to do. But, as usual, some legislators and doctors go overboard and put the requirements so low that actually it is a discrimination against our own men. After weeks of fighting, I feel requirements will be adequate as we see it now.

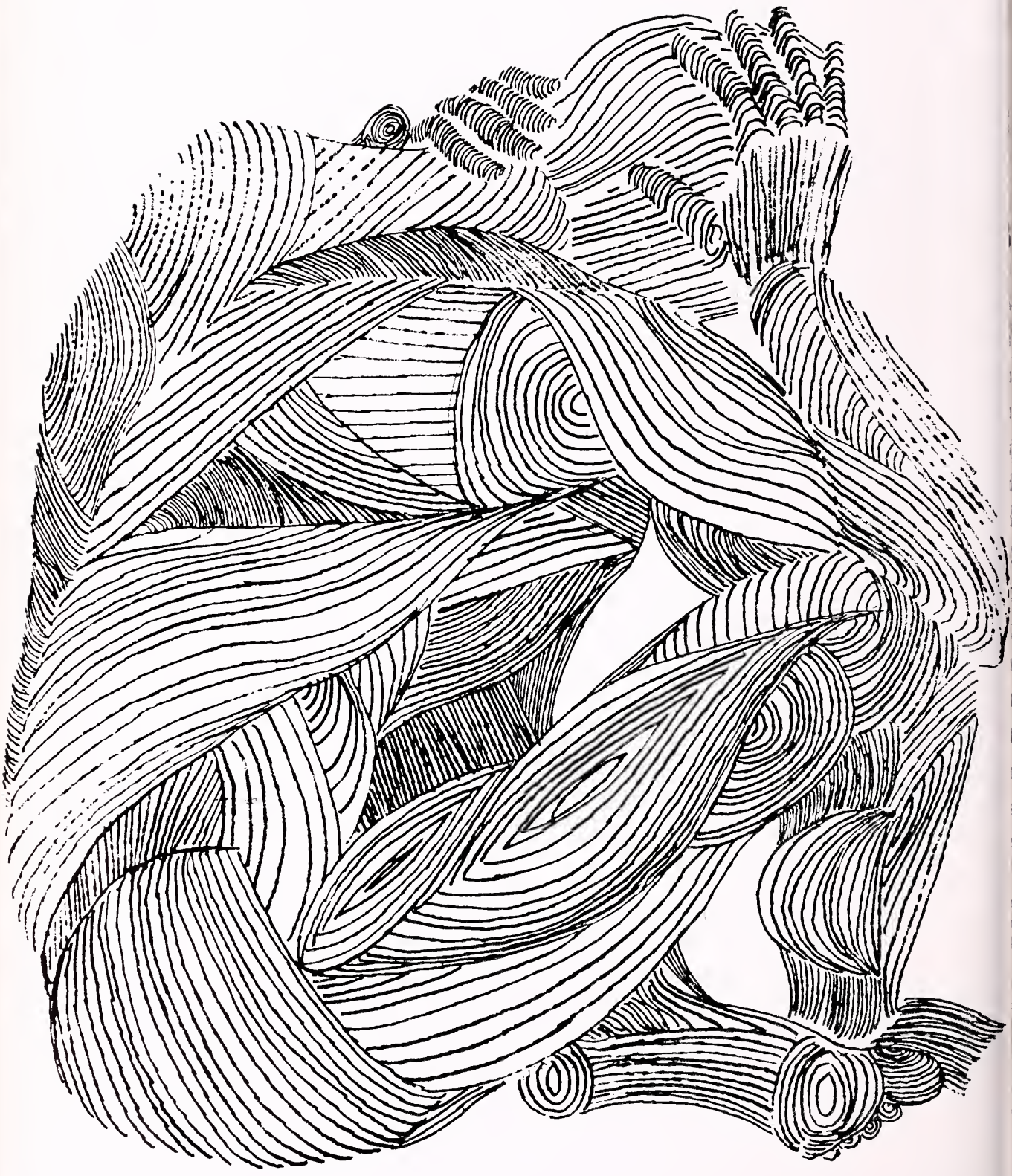
Another example is inclusion of reciprocity in the Medical Practice Act. This almost went through and it would have meant reciprocity with all states without examination. The idea may be to a degree good, however, there is just too much at stake to allow everyone in—the old, the feeble, the part time, the evil, and lord knows what. There is always someone who goes overboard with so-called good intentions—doctors and legislators alike. It is unfortunate that those who do go overboard just don't stay there.

Since my term is up, I had better play it smart and not make any predictions about anything because if I am not the boss, I can't make so many excuses and have them stick.

I would like to thank the members of the committees which have served this year and everyone of you that has spent so much time at meetings trying like most of us to have a first-class organization of vision and integrity.

Mahalo!

Edward Cushnie



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[EDITORIALS]

The Mabel L. Smyth Memorial Building

The attractive Mabel Smyth Memorial Building at the mauka corner of Punchbowl and Beretania Streets provides headquarters for the professional organizations of both nurses and doctors of the State of Hawaii. So far as is known there is no other building in the United States erected through the co-operation of the nurses and doctors to house their professional organizations under one roof and to serve also as a community center for other health and related activities. Dedicated January 4, 1941, to the memory of Miss Mabel L. Smyth, an outstanding Public Health Nurse, the beautiful building stands as a symbol of the community spirit between the local nurses' and doctors' organizations and the public.

While the need for a center for nursing activities had been discussed by the local nurses for some time, it was not until 1936 that definite steps were taken to provide such a building. About this same period the Medical Library, housed on the third floor of The Queen's Hospital, was outgrowing its quarters and the Medical Association was considering the possibility of making some arrangements between the Library and the Nursing Service Bureau and Physicians' Exchange in order to provide longer hours of service for the library. It seemed logical that these organizations related to the associations of the nurses and doctors should be housed in one building, and the first negotiations were begun at the Annual Convention of the Nurses' Association in January of 1936. Dr. Douglas Bell, the President of the Territorial Medical Association, attended this meeting and proposed the cooperation of the medical and nursing agencies in order to cut down on administrative costs and provide better service to its members.

Miss Mabel Smyth served on the committee of nurses and doctors to promote this accepted recommendation. While plans were being developed Miss Smyth died, on March 18, 1936. Her contributions to Hawaii and the nursing profession had been so many and of such far reaching qualities that it became the immediate project of the doctors and the nurses to dedicate the proposed building to her memory.

The result was that five years later the modern concrete structure with its air-conditioned auditorium and attractive lounge and lanai which through the generosity of Queen's Hospital, was erected on the hospital grounds now serves as a focal point for meetings and other activities. People from all the islands and even from the mainland contributed to this project. The medical center of the Hawaiian Islands, it is a semi-public building available to nurses, doctors, and health and welfare orginations, as approved by the Board of Management, which consists of two Registered Nurses representing the Hawaii Nurses' Association, two doctors representing the Hawaii Medical Association, and one layman representing The Queen's Hospital's Board of Trustees.

The agreement between these three organizations reads that they (the Associations) "do hereby guarantee to meet all expenses . . . necessary for the proper maintenance, care and upkeep" . . . "and further not to assign or transfer their equitable interest in the use of said Memorial Wing to any other person or corporation without prior written approval of the other Association and the Hospital" . . . "and it shall be binding upon and inure to the benefit of the parties aforesaid and their respective successors."

Thus the Nurses' Association, Territory of Hawaii and the Hawaii Medical Association became the guarantors of this eleemosynary, tax-exempt building, which is not endowed.

All maintenance and other expenses are derived from office and auditorium rentals plus the income from the Nurses' and Physicians' Exchange. The Exchange gives service 24 hours a day to private duty Registered Nurses and practical nurses, and to doctors who subscribe to the service. Service is also given to the Medical Society through the handling of calls on their Emergency Medical Service and all calls for people attending meetings in the building.

This year or early 1962 the Hawaii Medical Library will move out, into a beautiful new building adjacent to the Mabel Smyth Building, making available 1954 square feet of office space on the second floor.

Under the devoted and competent direction of Mrs. Illa V. Storme, with the guidance of its Board of Management, the Mabel Smyth Memorial Building is providing increasing services to Hawaii's nurses and physicians. Long may it thrive!

Medical Leadership in Rehabilitation

Rehabilitation has been talked about and written about until some of us are becoming ill from hearing about it. We might ask those who are saying the same things over and over again, "Why are you repeating yourself?" We might get the reply, "We haven't gotten the idea that you heard us the first, the second or even the third time."

Let us say once more that rehabilitation is a concept of patient management that demands multi-disciplined intercommunication if your patient is to realize his highest and best adjustment to his ailment, his family, his job and his community. To help him achieve a realistic goal instead of relegating him to a state of dependency may require the services of a number of medical and paramedical disciplines. Regardless of how knowledgeable and skilled the paramedical people are that are called in to serve your patient, the best efforts of the therapists are not assured of success; as a matter of fact, they are often doomed to failure unless you assert yourself as the leader of the team.

You can, if you wish, duck out of the whole affair by turning the leadership over to a medical colleague who has training and interest in chronic disease. If you don't do this, and don't take the leadership yourself, the paramedical people or "would-be doctors" are going to cry "neglect" and enthrone themselves on your seat and stir politicians to develop monstrous non-doctor organizations in which programs will be established, but into which you will be invited only when *they* want you.

R. Frederick Shepard, M.D.
Medical Director,
Rehabilitation Center of Hawaii

Honesty, Courtesy, and Ethics

The Board of Governors of the Honolulu County Medical Society adopted on March 21 the following policies recommended by the Medical Practice Committee:

(1) When issuing Sick Leave Certificates, the physician will be accurate and will be guided by actual circumstances. Under no conditions will he misrepresent the facts or assist the patient to defraud.

(2) The physician is obliged to protect the health of his patient to whom he owes primary responsibility. The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man and the rights of patients.

(3) A physician should seek consultation in doubtful or difficult cases, upon request, or whenever it appears that the quality of medical service may be enhanced thereby. Referral of a patient to another physician for consultation by an employer or an insurance company shall be done only after the attending physician has been notified.

(4) Acceptance of such a patient by the consultant shall be dependent upon previous communication with the attending physician. When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

(5) When a patient is sent to a consultant by an employer, insurance company, or physician, and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and an outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

These admonitions to be honest, courteous, and ethical should be unnecessary, but they are not. Let us all read them and heed them, to our mutual benefit and that of the patients we serve.

Infant Death Case Study No. 12

This 7 lb. 10 oz. Filipino boy was the product of a 40-week pregnancy, born at term in an urban hospital on December 24, 1959.

The mother was a 30-year old primipara. Her STS was negative and she was Rh positive. She first visited her doctor on June 27, 1959, followed by one visit each trimester. There was a 21 lb. weight gain. Past medical history was negative. It was noted that the mother had a rash on the head and neck. An allergic dermatitis appeared at the sixth month of gestation. The pelvic measurements were felt to be adequate.

Delivery was performed in the hospital by her physician. Labor lasted 15 hours and was terminated by "mid-low" forceps. There was a slight delay in initiation of respirations, but resuscitation was not necessary. Examination of the infant disclosed molding of the head, an intact Moro, and two "reddened streaks on the forehead, one anteriorly and one to the right." The infant took formula well and was discharged from the hospital on December 27. The only medication given was Vitamin K, 10 mg. I.M.

The infant was readmitted to this hospital on December 29 with a history of sudden onset of respiratory distress. Temperature 101°, respirations 104/min., and cardiac rate 180/min. Examination disclosed "moderate subcostal retractions. Diminished breath sounds and dullness, left lower lung with scattered moist rales." Chest x-ray: "Increased density over most of left hemithorax." A culture of the umbilicus was positive for Staphylococcus aureus, coagulase positive. No blood culture was obtained. The child was treated with penicillin, 150,000 units IM per day, and Chloromycetin, 125 mg. four times a day by mouth. The infant's condition gradually deteriorated and on January 2, 1960 the infant expired after several convulsions. Pediatric consultation was obtained when the infant became moribund.

Gross Necropsy Findings: The left wing of the tentorium was irregularly torn in the posterior region, along with a portion of the left transverse sinus, from which about 10 cc of blood had escaped into the subdural space and was pooled and clotted in the left occipital region. More fluid blood was scattered over the surface of the cerebral hemisphere.

The lungs presented smooth pleural surfaces. Their cut surfaces were light pink in color in a few aerated zones, but for the most part, were rubbery and dark red.

Microscopic Findings: The lungs showed intra-alveolar extravasations of blood cells and a few neutrophils in the larger bronchi. The remainder of the microscopic findings were not significant.

Cultures of the lungs showed only E. coli.

Discussion: The attending physician gave permission for Committee study of records. Information was not available on type of anesthesia, pelvic measurements, nor length of second stage of labor. Since mid-low forceps is an elective procedure, records should show indications. Perhaps more time should have been allowed for rotation and descent. Malapplication of forceps was suspected from marks described on baby's head. Death was considered to be due to pulmonary insufficiency, secondary to infection which could have been acquired after birth. The dosage of Chloromycetin was excessive. Pediatric consultation should have been requested earlier in the infant's course. One prenatal visit per trimester is not adequate prenatal care.

Classification: Urban, obstetric-pediatric death, preventable from a practical standpoint (if due to pulmonary insufficiency). Factors of preventability: Inadequate prenatal care, error in physician judgment and technic. Factors of responsibility: Physician, by failure to ask early enough for consultation, and by improper dosage of Chloromycetin; hospital, in allowing a physician who shows such errors in judgment and technic to care for obstetrical and newborn patients.

One of a series of case reports prepared by the Advisory Committee to the Bureau of Maternal and Child Health to illustrate the type of study made in the instance of an infant or maternal death in Hawaii.

This is What's New!

The polynesian kingdom of Tonga has been invaded electrophoretically to uncover the haptoglobins. The haptoglobins are a series of human serum proteins that are capable of binding hemoglobin. They are under genetic control. Whatever the anthropological implications may be, the **gene frequencies of Tongan haptoglobins** are more closely related to those of the **American Indians and Negroes** than those of the **Caucasians and Mongoloids.** (*New Zealand Med. J.* [Aug.] 1960.)

* * *

Advanced breast cancer is being treated in many areas by **hypophysectomy.** A group in Belfast carefully reviewed the records of 75 women treated in this manner. (Over half also had the emptied pituitary fossa packed with yttrium 90 oxide.) Best results: premenopausal women with osseous metastases (76 per cent had remissions). Age, total duration of the disease, and tumor histology had no influence on the response to hypophysectomy. (*Brit. Med. J.* [Mar. 4] 1961.)

* * *

Circulating **anti-thyroglobulins** are demonstrable in patients with **Hashimoto's disease** (lymphadenoid goiter), **primary myxedema,** and to a lesser extent, **hyperthyroidism.** These antibodies are detected by **tanned-red-cell-hemagglutination** (T.R.C.H.) test. Australian workers now find that hyperthyroids with exophthalmos are more apt to have high T.R.C.H. titers than hyperthyroids without exophthalmos. (*The Lancet* [Mar. 4] 1961.)

* * *

Also among the birds, only two hepatomas were found in **8,000 bird autopsies** at the Philadelphia Zoo prior to 1946. However, a **thirty-fold increase** in frequency of **hepatomas** (17 in 2,300) has occurred since 1946. A slowly progressive hepatitis preceded the hepatomas in all but one case. Social conflict rather than dietary difference is suggested as a possible cause to explain the development of the chronic hepatitis. (*Cancer Research* [Jan.] 1961.)

Gouty budgies (apparently the little buggers do get the gout) are best treated by painting the affected parts with tincture of iodine, feeding plenty of fresh greens, and boiling all drinking water before adding a pinch of sodium bicarbonate. (*Edinburgh Evening News* [Mar. 10] 1961.)

* * *

McMenemey of London in his presidential address discusses **immunity in neurological disease.** He gives strong support to his contention that the Lange gold curve can well be replaced by the more accurate and more revealing **CSF electrophoresis.** To assess production of globulin by the CNS, he advises both CSF and serum electrophoresis in all cases where immunity might play a role in neurological abnormalities. (*Proc. Royal Soc. Med.* [Feb.] 1961.)

* * *

Tetanus is the **commonest cause for admission** to the medical wards at the University College Hospital in Ibadan, Nigeria. Eighty-six cases of tetanus were admitted in 1958, of which 58 per cent died. **Infections,** including tuberculosis, accounted for **43 per cent of all deaths** on the medical service. (*The West African Med. J.* [Feb.] 1961.)

* * *

A Utah investigator finds no increased incidence of cancer of the stomach in husbands or wives of patients dying with the disease. This finding tends to support the existence of a **genetic** component in **carcinoma of the stomach.** It also tends to minimize the influence of an environmental factor, such as diet. (*Cancer* [Jan.-Feb.] 1961.)

* * *

Renewed interest in gene action has appeared with the more penetrating exploration of the gene borne diseases. An Illinois biologist present a hypothesis that would relate **acquired characteristics** to **genes.** In its simplest form, the hypothesis suggests that cytoplasm which acquires the capacity to **produce enzymes** may become a Mendelian gene. (*Nature* [Mar. 25] 1961.)

FRED I. GILBERT, JR., M.D.

One of the most effective arguments that can be offered against the "SOCIALIZED MEDICINE" concept

Meeting Medical Needs*

More than 41.3 per cent of the permanent population of Hawaii is enrolled in the Hawaii Medical Service Association, a pre-paid medical-surgical-hospital plan that operates as a "private enterprise."

Perhaps this is the best answer Hawaii can give to the idea of "socialized medicine." H.M.S.A. is not the only medical insurance program operating in Hawaii. Various insurance companies offer coverage of this type. The Kaiser Foundation has its own plan. Among them they provide protection to well over half the total population of the State.

* * *

H.M.S.A., according to the annual report of its president, C. T. Oliphant, hopes to increase its own membership this year beyond 50 per cent of the State's resident population.

Continued growth of the organization is essential if benefits are to be maintained without increases in dues (premiums). At present the H.M.S.A., according to Mr. Oliphant, is "recognized nationally as second to no other medical plan in the entire United States."

All of this has been achieved in 22 years. The H.M.S.A. was established in a rent-free office, with furnishings brought from homes and financed by donations from local business firms and individuals.

Today it has a total enrollment of more than 217,000 members and last year paid more than 300,000 claims totaling more than $8 million.

* * *

How well it has won the confidence of the community was established last year when 52 per cent of Federal Civil Service employees, with five medical plans to choose from, selected H.M.S.A. and 15 per cent did not participate in any plan.

Except for the medically indigent, who are inevitably a public charge, Hawaii's people seem to have spoken clearly for privately operated medical insurance in preference to government sponsored programs.

H.M.S.A. is one of the most effective arguments that can be offered against the "socialized medicine" concept.

* Reprinted from the March 26, 1961 Star-Bulletin

H.M.S.A. is dedicated to proving that a community through the cooperative efforts of its people, physicians and hospitals can best solve its own medical economic problems.

HAWAII MEDICAL SERVICE ASSOCIATION

HMSA®

Hawaii Medical Association

MINUTES OF THE COUNCIL MEETING

March 27, 1961, at 6:30 p.m.
Kauai Surf, Nawiliwili

PRESENT

Dr. Edward F. Cushnie, presiding; Drs. Allison, Benson, Burden, Giles, Goodhue, Nishigaya, Nishijima, and West plus Mr. Hugh Lytle, Dr. Clarence Carter and the following members of the Kauai County Medical Society: Drs. Boyden, Brennecke, Cockett, Fujii, and Wallis.

MINUTES

The minutes of the December 13, 1960, meeting were approved as published.

MINORITY REPORT FROM THE BUREAU OF CRIPPLED CHILDREN

Dr. Cushnie noted a letter from Dr. Morton E. Berk protesting a decision of the Advisory Committee to the Bureau of Crippled Children to set up a special fee schedule for the Bureau using 60% of the Honolulu County Relative Value Study with the currently approved contract conversion factor. Dr. Nishijima said he thought Dr. Berk had a good point. Dr. West thought the principle Dr. Berk supported was right in that every time you make a fee schedule you are inviting questions from other agencies who also negotiate schedules. Dr. Giles agreed and said he thought it was time that we set our fees and make no deviation except for charity patients. Dr. Allison said the purpose of the relative value schedule is to get all fees more or less uniform and that the fact the committee had approved the fees did not make them binding on the Hawaii Medical Association. Dr. West said that, according to the means test, if the patient is a charity case, it should be done for nothing. It is either the relative value schedule or nothing. Dr. Giles thought the fact that the Bureau could not take care of so many cases was not of prime importance. Dr. Allison didn't think there would be any shortage of services rendered.

ACTION:

It was moved and seconded to refer this back to the committee, giving them the sense of our opinion tonight and asking for a re-evaluation. The motion passed unanimously.

PHYSICIANS' OFFICES AT AIRPORT

Dr. Cushnie referred to the letter from Admiral Storrs which had been circulated. The question of whether doctors should bid for space for offices at the airport was discussed. It was noted that the Hawaii Aeronautics Commission stated orally that the lease for doctors' offices would not include the usual percentage clause and would be on a flat rate. Dr. Nishigaya thought we should make a survey to see if there is a need and defer making a decision until the results are computed. Dr. Nishijima thought we should get a clearer picture of what is involved. It was pointed out that the different airlines have their own physicians. Dr. Brennecke said that there were so many people out there that there might be a need. The suggestion was made that it could be handled in two ways—turn it over to the HAC to take bids or ask the HAC to let the Association decide on the bids. Dr. Moran didn't think it was the HMA's business unless the doctor kicks back a percentage of the money he takes in. If it is a simple matter of a doctor's renting office space, it is up to him.

ACTION:

It was moved and seconded that we write Admiral Storrs and tell him we have no objections to his dealing with the doctors to rent the space at the airport provided no percentage kick-back or free medical service is involved in the rental contract. The motion passed unanimously.

Dr. Burden said the question was on ethics and we should answer him on that only. If it is on a rental basis only, it is ethical but if the bid is for rendering service, then it is unethical. If he has an obligation to provide free services, then it is not all right. Dr. Allison said he wondered if any of these airline contracts had been solicited. In the absence of a physician in the area where the emergency occurs, the HMA should reaffirm its position that the injured employee should seek care from his own personal physician first.

MEDIC-ALERT FOUNDATION

The background of the Medic-Alert Foundation, details of which were circulated to the members of the Council, was discussed briefly and it was determined that all that was asked of the Council was approval.

ACTION:

It was moved and seconded that we approve the principle of the Medic-Alert Foundation. The motion passed unanimously.

AMA LEGISLATIVE MEETING

Dr. Cushnie asked Dr. Nishigaya to report on his recent trip to Chicago to attend the AMA conference on legislation. Dr. Nishigaya advised that the AMA took care of the expenses and every state in the Union was represented. A total of 277 doctors attended the meeting, which was called to appraise the administration's bill for care of the aged. Although the Forand bill did not get through the last session, there is a great need for the physicians to combine with other members of community and defeat the administration bill, HR 4222, introduced by King of California. This bill covers inpatient hospital services, up to 90 days, in excess of $10 for the first nine days, and full service cost of the remaining 81 days; 180 days nursing care after hospitalization; hospital outpatient diagnostic services over $20; and 240 daily visits for home health services. It does not cover physicians' services except those of the radiologist and pathologist in the hospitals. To finance these services, the social security tax would be increased to 6½ per cent on $5,000 annually. Without this, the law already provides that the tax go up to 9% by 1969. It is estimated that with the additional benefits this would go up to 11%, half of the payment to be made by the employer. The message to be carried back home was to try to implement the Kerr-Mills bill, enacted last year. The information on the King bill will be distributed to each of the neighbor island societies. The council member from each county will be the key legislative member to get the information to his society. It was felt that the

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In Memoriam--Doctors of Hawaii--XXXII

This is the thirty-second installment of In Memoriam—Doctors of Hawaii.

Donald Herbert Currie

Donald Herbert Currie was born in Kimmswick, Missouri, March 25, 1876, the son of Daniel McNeil and Martha McGill (Dent) Currie. He was the grandson of Archibald and Isabella (McNeil) Currie, both natives of Scotland, who immigrated to America in 1791 and settled in North Carolina.



DR. CURRIE

He graduated from the College of Medicine of Washington University, St. Louis, in 1897. Dr. Currie interned at St. Louis Hospital for one year and then went into private practice in that city.

In 1898 he joined the U.S. Public Health Service as assistant surgeon and served with that organization, with the exception of a two years' leave of absence, until his death. His first assignment was at Louisville, Kentucky, and from there he was sent to Washington, D. C., where he took special work in bacteriology. With the outbreak of bubonic plague in San Francisco in 1901, Dr. Currie was sent there to fight the disease and remained four years. His next assignment was at New Orleans where he battled the yellow fever epidemic.

On May 10, 1900, Dr. Currie was married to Helen H. Hanson in St. Louis. The couple had two children, John H. and Helen Currie.

In 1907 Dr. Currie came to Honolulu again to fight bubonic plague. Becoming interested in leprosy, he served as Dr. Brinckerhoff's assistant at the U.S. Leprosarium. When Dr. Brinckerhoff left in 1910, Dr. Currie became director. In 1909 the doctor was a representative of the United States at the International Leprosy Congress in Bergen, Norway.

Leaving the Islands in 1911, Dr. Currie was transferred to Angel Island, San Francisco, where he was in charge of the U.S. Public Health Service hospital. In 1915 he returned to Hawaii and for a second time was director of the U.S. Leprosarium.

In August, 1917, he was appointed Chief Quarantine Officer for the Port of Boston and held that position until his death in Brookline, Massachusetts, December 23, 1918, at the age of 42.

He was a member of the Association of Military Surgeons of the United States.

John Rae

John Rae was born at Footdee, a suburb of Aberdeen, Scotland, June 1, 1796. His father, John Rae, Sr., was a shipbuilder and ship broker. His mother, Margaret Cuthbert Rae, died when he was still a youth.

He entered the University of Aberdeen when he was only 14 years old, and received his M.A. in 1815. According to the *Dictionary of American Biography*, young Rae studied medicine at the University of Edinburgh and, though he was afterwards known as Dr. Rae, he did not take his medical degree because he was "discouraged from presenting his inaugural dissertation which embodied a revolutionary view of physiology." Quoting again from the same source, "he had come to the conclusion that the physiological medical theories of the day were opposed to all true philosophy and his theory of the origin of man was very different from the orthodox one."

Following his years at the University of Edinburgh, it is believed that Dr. Rae went to Paris for additional study, and in 1818 he toured Norway. During this period he began to make a study of the history of society "believing by gathering together all that consciousness makes known to us of what is within and all that observation informs us of what lies without—might be—discovered—the materials for a true natural history of man." However, his study was cut short when an expected inheritance did not materialize and by a "hasty marriage to the daughter of a Scotch shepherd."

In 1821 he emigrated to Canada where he established a private school for the children of fur traders of the Hudson's Bay Company at Williamstown, 50 miles from Montreal. Ten years later he abandoned this project and lived in Quebec, Montreal, and Boston while he worked on a manuscript entitled, "Statement of Some New Principles on the Subject of Political Economy, Exposing the Fallacies of the System of Free Trade, and of Some Other Doctrines Maintained in the 'Wealth of Nations.'" His book was published in Boston in 1834, where its reception was lukewarm. Soon after its publication, Rae became headmaster of the Gore District Grammar School at Hamilton, Ontario, where he was said to have gained the affection and respect of his pupils more through his scholarship and friendliness than through his teaching ability.

In December, 1837, Dr. Rae joined the Hamilton Volunteers and went to Toronto and to the Niagara frontier to fight in the rebellion against the British government in Canada. The following year the trustees of the school ousted him, apparently on the grounds of being a freethinker or at least being opposed to the privileges of the Church of England.

In 1849 Dr. Rae's wife died.

The doctor went to Boston and then to New York where he taught for a short time. From New York he sailed to the Isthmus of Panama, and from there as ship's doctor, he sailed on the "Brutus" for California, which was in the midst of the gold rush. Apparently immune to gold fever, he taught school near Sutter's Creek and made cradles for washing gold and balances for weighing it.

Taking passage on the "Waterlily" he arrived in Honolulu March 11, 1851. Dr. Rae settled at Hana, Maui, where he became a medical agent and later a district judge. In the smallpox epidemic of 1853, Dr. Rae in a letter written from Hana and published in the "Polynesian" of September 24, 1853, stated that he had encountered smallpox three different times in his career, once when serving his apprenticeship in Scotland and twice while practicing in upper Canada, and blamed the government for failing to take proper steps to stop the

(Continued on page 495)

Book Reviews

★Obstetrics

By J. P. Greenhill, M.D., F.A.C.S., F.I.C.S. (Hon.) 1098 pp., $17.00, W. B.. Saunders Company, 1960.

Over the past five years (since the 11th edition) there have been many significant advances in all fields of medicine. Many new concepts that influence the obstetrician are most clearly presented by the author and the 23 contributors. Bibliographies indicate incorporation of extensive research materials as well as original investigations by authoritative specialists in the various fields of medicine and surgery.

Many new and valuable chapters have been incorporated. Outstanding are those related to physiology and biochemistry of the placenta, obstetric roentgenology, and diseases of the various systems including the endocrine.

There are 162 new illustrations which increase the total to 1,219. The figures were also increased by 60. This truly is one of the most up-to-date texts in obstetrics.

SAMUEL J. BUIST, M.D.

Total Surgical Management

By James D. Hardy, M.S., M.D., F.A.C.S., 292 pp., $9.50, Grune & Stratton, 1959.

This is an excellent book not only for the surgeon but for the internist, and for the general practitioner who operates occasionally. This book by James Hardy is another one of his practical books on the pre and postoperative care so essential in the welfare of a surgical patient. It is recommended that it be included in the library of the private practitioner for general use.

WALLACE W. S. LOUI, M.D.

Respiration

Edited and Translated from the German edition by Peter C. Luchsinger, M.D., and Kenneth M. Moser, M.D., 505 pp., $15.75, The C. V. Mosby Co., 1960.

Although this represents the German viewpoint of pulmonary diseases and function, it nonetheless would be of interest and use to the student or researcher in this field. The authors have covered the subject comprehensively and bibliography is complete.

BERNARD J. B. YIM, M. D.

★Diabetes, With a Chapter on Hypoglycemia

Edited by Robert H. Williams, M.D., 54 authors., pp. Paul B. Hoeber, Inc., 1960.

This volume stands to be a classic in its field for years. It is authoritative and comprehensive. Fifty-four experts contribute various sections. Despite this, the volume reads well and duplication is minimized. One would highly recommend this volume to be included in the library of all physicians dealing with the disease.

BERNARD J. B. YIM, M. D.

Tensions—And How To Master Them

By George S. Stevenson, M.D., and Harry Milt, 28 pp., $0.25 Public Affairs Pamphlets, 1960.

This little Public Affairs pamphlet of 28 pages may be useful reading for non-psychiatrists who frequently see anxious patients. The nature of symptoms and tension and suggestions for relieving mild cases are explained in language easily understood by the layman, but based on sound psychological principles. Since the pamphlet is available for 25¢ some physicians may wish to obtain copies to distribute to patients who might respond to simple reassurance and direct suggestions.

KENNETH H. RUSCH, M.D.

★Adventure to Motherhood

The Picture Story of Pregnancy and Childbirth. By J. Allan Offen, M.D., $2.95, Taplinger Publishing Co., Inc., 1960.

This seems to be one of our best recent contributions in prenatal literature which can be highly recommended as a most useful reference. It is particularly impressive in that it contains 64 illustrations. These appear to be highly accurate and cover the subject material very adequately.

One could highly recommend this most useful source of information to prenatal patients.

S. J. BUIST, M.D.

★The Management of Fractures and Soft Tissue Injuries

By the Committee on Trauma, American College of Surgeons, 372 pp., $5.00, W. B. Saunders Company, 1960.

This is a handy, pocket-sized combination volume on the treatment of fractures and soft tissue injuries. Principles of treatment as well as management of specific injuries are succinctly given. In addition, there are laudable sections on burns, shock, infection, and the care of the patient with multiple injuries.

This is a well composed and useful manual which should be in every emergency room and in the working library of physicians treating injuries.

S. L. YEE, M.D.

Also Received

Pediatric Clinics of North America, Vol. 7—No. 4

William L. Bradford, M.D., Consulting Editor, 293 pp., $3.75, W. B. Saunders Company, 1960.

Infectious diseases—by 17 contributors. Index issue.

Light Coagulation

By Gerd Meyer-Schwickerath, M.D., and translated by Stephan M. Drance, M.B., F.R.C.S., 114 pp., $9.50, The C. V. Mosby Company, 1960.

Valuable treatise on a special surgical modality—for ophthalmologists.

★CIBA Foundation Symposium on Congenital Malformations

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Cecilia M. O'Connor, B.Sc., 308 pp., $9.00, Little, Brown & Company, 1960.

Excellent reference volume, like all CIBA symposia. Obstetricians would find it most valuable.

(Continued on page 490)

★ Highly recommended.

Notes and News

Names in the News

HMA's "Common Skin Problems" highlighted **Drs. Allison, Emuro,** and **Johnson,** recently, on KONA-TV. **Dr. Nothon Shklov** was recently appointed a Fellow of the American School Health Association.

Chock-Pong Clinic doctors made headlines protesting the relocation of a mortuary next door. Is this a true "life and death" story?

Dr. George Goto learned practical politics during testimony on HB-914 which he had had introduced by request. Ditto members of the Legislature Committee, and doctors who testified on the various aspects of the many bills pertaining to medical practice in the House.

Dr. A. V. Mojosko, City Medical Examiner, learned on query that autopsy reports are public information.

Maluhia Hospital Advisory Committee (advisory committee to the Mayor) made quite a stir at a recent meeting when Mayor Blaisdell asked for flat rates for all hospital indigents.

Dr. F. J. Pinkerton has again been elected President of the Blood Bank of Hawaii. **Dr. Duke Choy** discussed "Hypnosis" at the installation dinner of the Hawaii Association of Medical Record Librarians.

The Kaiser-PMA hassle is still making headlines by suits and countersuits.

Wine selector **Dr. D. C. Marsholl** looked trim and professional at the annual dinner of the Honolulu Wine and Food Society.

Drs. Dovid Pong and **A. Ng-Komsot** took active part in the Mun Lun School's 50th Anniversary.

Dr. Mory A. Glover, recently returned from her experiences with the USS "Hope," still keeps the public informed through her articles and public appearances. **Dr. H. L. Arnold, Jr.,** also made available for public consumption recent lectures by P.G. lecturers **Drs. Frozer** and **Cope.**

Dr. I. A. Kowosoki, S. Yee, and **Thomos Chong** were recent golf tournament winners at Waialae.

HMA's get acquainted shindig for legislators caught the fancy of local columnists and made good news.

Dr. Y. Fukushima and **K. Kuramoto** got legal tax deductions by purchasing art works at auction at a recent Heart Fund party.

Dr. Clarence Fronk still makes news with his favorite hobby. Two of his horses have been accepted for the 1964 Olympics.

Dr. George H. Mills was elected President of the new Honolulu Foundation for Medical Care. Also named were **Drs. M. Berk,** Vice-president, **J. M. Felix,** Secretary, and **Wm. Ito,** Treasurer. Board members are **Drs. S. D. Allison, R. D. Moore, R. A. Nishijimo, H. Q. Pong,** and **T. Tomita.**

Dr. N. P. Lorsen had a famous Madge Tennent painting stolen. Also, he gave good advice on "Husband Preservation" at a Junior League meeting.

Pres. Edword Cushnie, M. Berk, and **H. L. Arnold** took issue with President Kennedy's medical care program for the aged and raised the ire of the AFL-CIO Central Labor Council.

Dr. Jeonette Chong was guest speaker at the Chinese Women's Club. Her subject: "Milady's Heart."

Ex Sec (HCMS) Dick Kennedy offered a resolution in the House of Representatives proclaiming March 30 "Doctors Day." Of interest and of some concern to the profession is the fact that there were *some objections!!!* Our PR still needs bolstering.

Dr. Robert S. Simpson has begun exercise group classes at the Foster Village for the Physical Fitness Program.

Dr. Horold Civin was a judge at the recent Science Fair.

Dr. Unoji Goto has been named to the National Foundation's Health Scholarship Committee for Hawaii.

Dr. Archie Chun-Ming's office was recently burglarized. Syringes and sleeping pills were taken—a drug addict being suspected.

Congratulations!

To **Dr. Richord K. C. Lee** on the completion of 25 years of service to the Health Department.

Dr. Thomos Y. K. Chang as the new member of the Hawaiian AAU Boxing Committee replacing the late **Dr. B. N. Iwanoga**—also as physician for the Boxing Commission.

To the Health Department for its new building "Kinau Hale" across the street from the Mabel Smyth. Must be a joy and pleasure after 72 years in the old Kapuiwa Building.

Drs. L. Q. Pang, Richord You and **Pete Okumoto**—recently appointed Regents of the University of Hawaii. Dr. You has been elected Vice Chairman of the Board and also Vice President of the Honolulu Stadium Board of Directors.

Straub Clinic's senior members, **Drs. Strode, Stroub,** and **Arnold, Sr.,** and **J. Palmo,** celebrated the 40th anniversary of the Clinic's founding. All members of the Clinic had a gala time at its celebration.

Dr. Franklin Wong of Hilo has been appointed AAU Commissioner for the Island of Hawaii. **Drs. H. Nam** and **T. K. Y. Chong** were named co-chairmen of the Medical Advisory Committee of the local AAU.

Dr. Chisoto Hoyoshi of Kona has been named Chairman of the Hawaii County Police Commission for 1961.

Dr. M. J. Avecillo was recently elected to the Board of Directors of the City Bank of Honolulu.

The Hawaii State Hospital at Kaneohe was notified in January, 1961, by the Central Inspection Board of the American Psychiatric Association that it is now fully approved as a psychiatric hospital.

Obituary

The medical profession was shocked by the unexpected passing of **Dr. Borney N. Iwonogo** at his home. Many tributes were paid him for his longstanding contribution in Boy Scout work and for his participation in the Hawaiian AAU.

Also shocking was the death of **Dr. Chorles E. Price** who was killed in an automobile accident on Molokai where he had gone into private practice after serving as assistant administrator and medical director at The Queen's Hospital.

Oldsters in the profession also noted with sadness the passing of **Dr. Wm. H. Wynn,** a former practicing physician here, who died in New Orleans.

New Faces—New Affiliations

Dr. Jomes T. Leong, OB-Gyn, announces the opening of offices at Room 1, 1319 Kalakaua Avenue. **Dr. Clorence S. Sokoi,** surgeon, has associated with **Drs. V. C. Woite** and **R. S. Omura** in colon and rectal surgery. **Dr. Thomas W. Cowon** has moved to Kailua—at 324 Kuulei Road. **Dr. Kooru Sosaki** has joined **Dr. Alon Luning**

at 45-939 Kam Highway. **Dr. Florence J. Chinn,** internal medicine, was recently welcomed into the HCMS and is practicing at the Professional Center Building.

Dr. Homer M. Izumi is now doing solo practice at the King Center Building. **Dr. Stuart N. Calhoun** has been named chief, Diamond Head Mental Clinic.

Dr. Raymond P. Westover is the new director of the outpatient Clinic in the Honolulu Veteran Administration's Regional Office. He succeeds the late Erwin Cheim and comes from the Portland, Oregon, offices.

Drs. M. L. Hanlon, W. E. Iaconetti, Seiya Ohata, W. B. Patterson, L. S. Rockett, E. T. Shimokawa, M. Tofukuji, and **W. G. Pfaeltzer** moved into their new Maui Medical Group Building which had an official opening ceremony in Wailuku, March 12.

Travel News

Dr. and Mrs. John Milnor attended the spring sessions of the American Academy of Pediatrics and visited relatives throughout the country. They devised an ingenious method to keep their stay-at-home children occupied and busy by prearranging a daily treasure hunt.

Dr. and Mrs. D. C. Marshall are taking a delightful tour of Europe this spring. After flying to Copenhagen they will pick up a car in Frankfort and spend several months touring.

Dr. R. Varian Sloan returned from the mainland to attend a regional meeting of the AAGP and is off again to the annual meeting in Miami, Florida.

Dr. Leabert Fernandez shirked his legislative duties to attend the plastic surgeon's meeting in California.

Dr. T. Nishigaya was one of 277 who recently attended a Medical Legislative Conference of the AMA in Chicago, Illinois.

Dr. Patrick M. Cockett attended the April Industrial Medical Association convention in Los Angeles.

Local Doctors in Print

Drs. Ralph M. Beddow and **Irvin L. Tilden** are coauthors of a case report on "Malabsorption Syndrome Due to Amyloidosis of the Intestine Secondary to Lepromatous Leprosy," which appeared in the November, 1960 issue of *Annals of Internal Medicine*. **Dr. W. J. Holmes** had an editorial on "Asia-Pacific Academy of Ophthalmology" in the January, 1961 issue of the *American Journal of Ophthalmology*. The following issue of this Journal carried his "Report on Glaucoma in the Pacific." The April 15, 22, 29 issues of JAMA carried a three-part narration on American Medical Aid to Asia written by Dr. Holmes.

Dr. Harry L. Arnold, Jr. wrote a short article on neurodermatitis in Howard Conn's *Current Therapy—1961*.

Straub Research Institute

Dr. Joseph E. Strode announced in April the organization of the Straub Medical Research Institute of Hawaii, and said the first two grants for research and education already had been made.

A grant of $500 was made to **Dr. L. T. Chun,** a Honolulu pediatrician, to partially defray the cost of his proposed investigation into the types of streptococci associated with rheumatic fever in Hawaii.

Another grant of $100 was made to help finance the special March-April issue of the HAWAII MEDICAL JOURNAL devoted to surgery for the acutely injured. The McInerny Foundation agreed to make up the balance of extra cost for this special issue.

Dr. Harry L. Arnold, Jr., president pro tem of the institute, said the primary purpose of the newly formed corporation is the fostering of medical research in this community.

Straub Clinic physicians on the board of directors number only six in a total of 13. Medical members of the board of directors are **Drs. George F. Straub, Joseph E. Strode, Harry L. Arnold, Jr., Alfred S. Hartwell, Rodney T. West, Robert G. Rigler, L. Q. Pang, Kazuo Miyamoto,** and **Grant Stemmermann.**

Lay members of the board are Robert Midkiff, Dean Witt, E. C. Moore, Jr., and Hugh W. Lytle.

Initial grants to the institute have been made by J. C. Earle, by the Straub Clinic and by Dr. George F. Straub, the Clinic's founder.

Thoughts

Knowledge comes, but wisdom lingers.

ALFRED LORD TENNYSON

CHARLES E. PRICE, M.D.
1916-1961

Dr. Charles E. Price, former Medical Director at The Queen's Hospital was killed Wednesday, February 1, 1961, when his car went out of control on Molokai. Dr. Price had been in practice with Dr. William R. Totherow since November 1, 1960.

Dr. Price, 45, was a native of Philadelphia, Pennsylvania, where he was Medical Director of Hahnemann Hospital from 1947 to 1953. He graduated from Temple University Medical School in 1939, interned there and served his residency in surgery at Norristown, Pennsylvania. During World War II, Dr. Price served in the U.S. Navy aboard the Montauck PT in the South Pacific. He served as consultant for the National Polio Foundation until 1958 when he accepted the appointment as Medical Director at Queen's.

He is survived by his wife, Marie; three children, Charles E., Jr., Robert Michael, and Jane Elizabeth, and two sisters, Mrs. Helen Johnson and Mrs. Ruth Joline of Philadelphia.

WILLIAM TOTHEROW, M.D.

County Society Reports

Hawaii

A breakfast meeting was held on February 19, 1961, at the Hilo Hotel. Guest speaker was Dr. Oliver Cope.

Dr. Oliver Cope gave an interesting and informative talk on "Hyperthyroidism: Considerations of the Choice of Therapy and Practical Programs of the Patient Management."

A breakfast meeting was held on February 26, 1961, at the Hilo Hotel. Guest present was Dr. Russell Fraser.

The next order of business concerned a letter written by Dr. Harry L. Arnold, Secretary of the Board of Medical Examiners, requesting the Hawaii County Medical Society to send a letter to the Board of Medical Examiners requesting waiver of residence requirement for Dr. George Bracher so he can apply for licensure. Dr. Wipperman moved, seconded by Dr. Woo, that a waiver be requested. The motion was unanimously carried.

The next items brought up for discussion was in regard to the Polio Immunization Program. Dr. Woo moved, seconded by Dr. Loo, that we accept the free polio program in which oral polio vaccine be given to all children in Hawaii between the ages of one month and 18 years of age and that the Legislature should budget sufficient funds for the project as recommended by the Polio Committee of the Hawaii Medical Association.

Following the business portion of the meeting, Dr. Russell Fraser gave an interesting and very informative talk on "Current Clinico-endocrinologic problems."

The March 13, 1961 meeting was held at the Hilo Hotel. Guests present were Drs. Stockinger, King, and William Davis, Sr.

The business portion of the meeting was followed by interesting and informative talks on "Hematuria" by Dr. Richard Stockinger and Dr. James J. King, both Associate Professors of Urology at Marquette Medical School.

FRANCIS F. C. WONG, M.D.
Secretary

Honolulu

The Honolulu County Medical Society met on Tuesday, January 10, 1961, in the Mabel Smyth Auditorium. The meeting was called to order by President Hartwell at 7:30 P.M.

American Red Cross:

A certificate of appreciation was presented to the doctors of the Honolulu County Medical Society by a representative of the American Red Cross for the medical profession's splendid cooperation during the past years.

New Members:

The following new members were welcomed into the Society: Drs. Lino M. Lapenna, Herta Renner, Monroe W. Spero, Alvin Szojchet and Herman P. Kramer.

It was announced that Dr. Young P. Kang was granted a life membership in the Society by the Board of Governors.

B.M.E. Annual Report:

Mr. Kennedy presented the annual report of the Bureau of Medical Economics, a copy of which is on file. He projected on the screen a picture of the proposed budget for 1961 giving a brief explanation of each item and also answered questions regarding the budget.

Public Relations Committee Report:

Dr. William Stevens, chairman, proposed the following recommendations to the membership: (1) Vote of approval for a more vigorous and effective public relations program for all physicians in Hawaii and (2) vote to assess each member $15.00 to get this program rolling in 1961.

Dr. Stevens gave a brief summary of the Public Relations Committee's program. He stated that the Board of Governors has approved a request from the Hawaii Medical Association that each county society be asked to assess its members $15.00 for 1961 to finance an $8,000 first-year cost for a PR program. This would enable the Association to hire a public relations counsellor (Mr. Hugh Lytle) on a part time basis, as well as meet other expenses.

A movie entitled "Eye of the Beholder" was shown followed by the presentation of three well known individuals outside the medical profession who gave their impressions of the medical profession.

Mr. Donald Ching of the Hawaii State Legislature—A Legislator's view of the physician.
Mr. Robert Craig of Craig & Craig Associates—A public-eye view of the physican.
Mr. Hugh Lytle—A newspaper man's view of the physician. Mr. Lytle also presented the highlights of his recent PR survey of the medical profession.

ACTION:

It was moved by Dr. Walsh to approve the assessment of $15.00 on each member of the Medical Society to be used for the proposed PR program of the Hawaii Medical Association including the part time services of Mr. Hugh Lytle. The motion was seconded. Voting was held by ballot. Tellers appointed to count the ballots were Drs. H. Q. Pang, M. E. Stevens and F. Shepard. It was announced by the Chair that the motion was carried with a vote of 89 in favor and 6 against.

ACTION:

It was moved by Dr. Palma that Dr. Stevens and his committee be applauded for an excellent presentation. The motion was carried unanimously.

Fee Adjustment Committee Report:

Dr. Freeman of the Fee Adjustment Committee was present to explain the committee's recommendations which had been referred back to the committee by the membership at the last meeting for further study, and were now being presented again to the membership for approval.

The recommendations were acted upon as follows:

Hemodialyis with artificial kidney (management of the artificial kidney) be listed as 5.0 units in the medical section of the Relative Value Schedule and that the HMSA fee be $25.00 per hour while the physician is in physical attendance without any limitation of number of hours, and that any repeat procedures be paid at 50% of the $25.00 on an indemnity basis.

ACTION:

It was moved, seconded and carried that the above recommendation be approved.

Myringoplasty: The committee reaffirms its recommendation that this procedure cover all cases and that

(Continued on page 490)

Winslow Homer "THE HERRING NET" *Art Institute of Chicago.*



STRAIN

Strain is a necessary component of man's efforts to move his external environment, but all too often brings on extreme pain and trauma when hard stools are moved after repair of rectal disorders. Metamucil adds soft, bland bulk to the bowel contents to stimulate normal peristalsis and also hold water within stools to keep them soft and easy to pass. Thus Metamucil, with an adequate water intake, is of great help in minimizing painful trauma to postsurgical rectal tissue. Metamucil promotes regularity through "smoothage" in all types of constipation.

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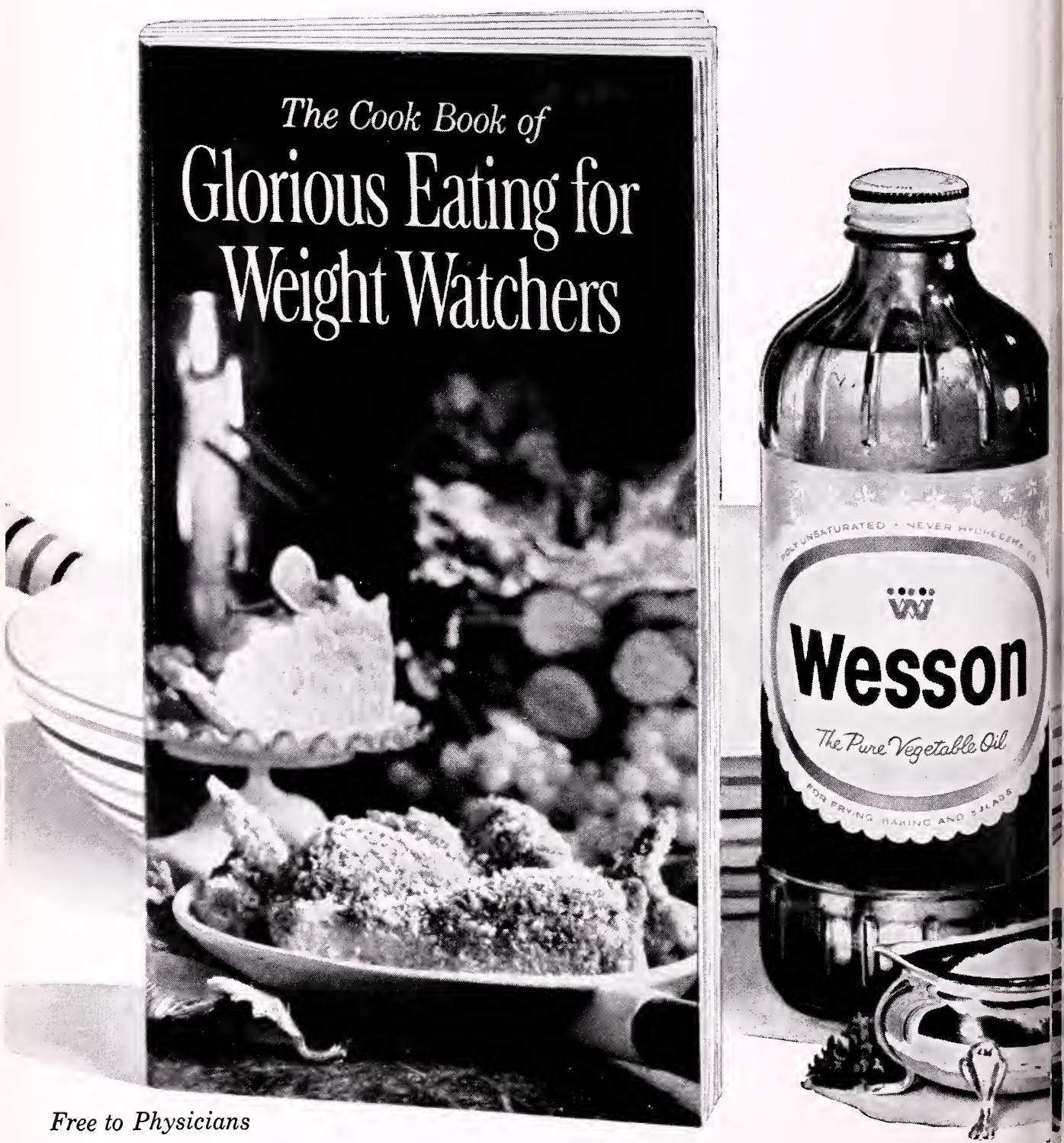
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Menus fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Counci

Prevent Overweight Through Better Eating Habits

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The Cook Book of Glorious Eating for Weight Watchers fills the long-felt need for a weight control plan that is workable for everybody in the family. Realistic regimens are built around good, natural, readily-available foods enhanced by delicious methods of preparation. In place of "fad diets" or tasteless formulas, it provides for truly appetizing meals. It teaches and encourages the development of the healthful eating habits that can prevent overweight, America's #1 Health Problem. This full-color cook book contains 100 pages—248 delicious recipes each with calorie counts. Complete menus are here at 3 calorie levels—1200, 1800, 2600. Calorie levels are related to *best* weights by sex, age, size and extent of activity.

Many diets fail because they are crash programs only temporary in effect. Other diets are unbearable because they are monotonous and tasteless.

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Copies for physicians. "The Cook Book of Glorious Eating for Weight Watchers" is being offered to the general public. If you would like a copy for yourself, together with forms to enable patients to obtain their own copies, please fill in coupon below.



Note: *Please do not confuse this booklet with the Cholesterol Depressant Diet Book, published by Wesson as an aid to physicians and* for professional distribution only. *The concept of the Cholesterol Depressant Diet Book stems from Wesson's value in cholesterol depressant diets. Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, poly-unsaturated Wesson is unsurpassed by any readily available brand.*

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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Hawaii Nurses Association

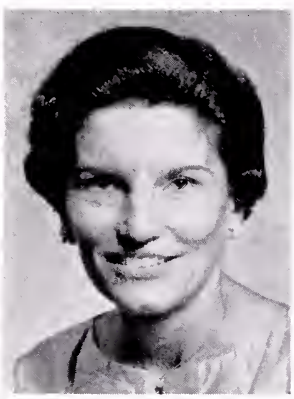
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MILDRED KIM, *Associate Editor*

ROSE ANN POYZER, *Executive Secretary*

HNA Executive Secretary Appointed

Mrs. Rose Ann Poyzer was appointed by the Hawaii Nurses Association as the new executive secretary. Mrs. Poyzer comes to Hawaii from North Dakota.



MRS. POYZER

Mrs. Poyzer is the wife of Dr. Marvin Poyzer, a faculty member of the University of Hawaii in the College of Education, is organizing a new program in Industrial Education. They have a four-year-old daughter, Barbara Lou.

Mrs. Poyzer is a graduate of the College of St. Catherine, St. Mary's Hospital Unit, Minneapolis, Minnesota, and the Catholic University of America, Washington, D. C. She was an instructor at St. Mary's Hospital, Minneapolis, Minnesota; instructor at Methodist Hospital, Peoria, Illinois; Instructor and assistant director at Sisters of St. Joseph School of Nursing, Grand Forks, North Dakota.

In the North Dakota State Nurses Association she has been on the Board of Directors, chairman of the Administrative Section, and has held several offices and been active on the district level through committee work. She has been chapter and diocesan president of the Catholic Nurses Association in North Dakota.

ANA Legislative Conference

Mrs. Rosie Chang, Chairman of the HNA Legislative Committee, was among the 150 nurses from all parts of the country convening in Washington, D. C., March 22-24, for a conference on legislation sponsored by the American Nurses' Association.

Senator Jacob K. Javits (R., N.Y.), Senator Metcalf (D., Mont.), and Representative John E. Fogarty (D., R.I.) headed the list of prominent persons from Congress, government agencies, and other professional groups who were conference speakers.



MRS. ROSIE CHANG with Senator Oren E. Long in his Washington office.

Nurses attending the conference were chairmen of their state legislative committees or staff members of state board of nursing who administer the nursing practice acts. Purpose of the conference was to coordinate legislative activity on the state and federal levels, to provide information on legislation of special interest to the nursing profession, and to discuss current legislative aims.

One day of the conference was spent on Capitol Hill. Mrs. Chang visited Congressmen Long, Fong, and Inouye. A dinner was held that evening, March 23, at the Sheraton-Park Hotel to discuss their visits. Two Capitol Hill experts directed the table talk: James Harrison, administrative assist-

ant to Congresswoman Edith Green (D., Ore.); and John Gunther, general counsel, Conference of Mayors of the United States.

Topic for discussion during the two workday sessions included "The Professions and Government"; a three-member panel discussion of the "Influence of Administrative Agencies on Legislation"; "Congressional Responsibility for the Budgetary Process"; a briefing on ANA's current progress in federal legislation; "Society and the Professions"; "Issues Involved in Public Funds for Higher Education"; and four divergent approaches to the problem of licensure and control of professional practice.

The nursing profession's current major legislative interests are improvement of state licensing laws, wherever present laws do not adequately protect the public and the nurse; legislation to provide funds for aid to collegiate nursing education programs, and legislation that would bring nonprofit hospitals under labor laws thus ensuring employees the right of collective bargaining.

The American Nurses' Association is the national professional organization for professional registered nurses. It has constituent units in the 50 states, District of Columbia, Canal Zone, Puerto Rico, and the Virgin Islands.

ANF Board of Directors

Dr. Joseph Clarence Hinsey, Director, The New York Hospital-Cornell Medical Center, and Bruce Y. Brett, President of the Macmillian Company, have been named to the Board of Directors of the American Nurses' Foundation, national center for research in nursing.

Dr. Hinsey, trustee and member of the Committee on Scientific Policy of the Memorial-Sloan Kettering Center, and trustee and chairman, China Medical Board of New York, was formerly dean of Cornell University Medical College.

Mr. Brett is the fourth generation of the Brett family to head The Macmillan Company, one of the world's largest book publishing houses. He resides in New Canaan, Conn.

Also elected to the Foundation Board of Directors were Mathilda Scheuer, R.N., Philadelphia, Pa., president of the American Nurses' Association, national professional organization of registered nurses; Julie M. Carnahan, R.N., New Orleans, La., surgical supervisor of the Oschner Clinic; and Mrs. Georgia B. Nyland, R.N., head nurse of the Indiana University Medical Center, Out-Patient Clinic, Indianapolis, Ind.

Besides the president, Agnes E. M. Anderson, executive secretary of the Pennsylvania Nurses' Association, Harrisburg, Pa., three present members of the board were re-elected. These are Roy W. Bixler, Decatur, Ga., formerly registrar of Drake University; Dr. Henry T. Clark, Jr., administrator of the Division of Health Affairs, University of North Carolina, Chapel Hill, N. C. and Ruth E. Bagley, R.N., director, St. Anselm's College Department of Nursing Education, Manchester, N. H.

The American Nurses' Foundation, a membership corporation, was established in 1955 by the American Nurses' Association to support and conduct effective research in nursing and patient care.

Extensive Agenda Marks Annual ANA Board Meeting

The ANA Board of Directors, meeting in its annual January session, January 24-30, acted on the 1961 budget, considered more than 30 reports from ANA officers, special, standing and section committees and gave attention to several communications from allied health organizations and agencies.

Members of the Board also convened in their capacity as stockholders of the American Journal of Nursing Company, wholly-owned subsidiary of ANA, and as members of the American Nurses Foundation to hear reports of operations and activities.

The Board discussed matters about which they wish to confer with SNA representatives in New York, June 26-28.

Following are highlights of action taken during the Board meeting:

1961 Budget Review: ANA membership declined slightly in 1960 (1.4 per cent) from 1959 requiring a careful review by the Board of the 1961 budget in an effort to bring it in line with anticipated dues income for the year. (The budget for each year is based on anticipated membership dues projected from membership figures for the previous year.)

The failure of ANA income to increase in proportion to rising demands for ANA services, expanding program, growing responsibilities, and rising costs presents a chronic problem, and the present decline in membership has necessitated the elimination of certain planned activities and left no leeway for expansion or increasing services.

Reduction or elimination of certain planned expenditures was authorized for the first six months of 1961 pending a further appraisal at the June meeting of the Board. Reductions relate chiefly to the production and distribution of newsletters and other printed materials, consultant services, workshops, and conferences, and the purchase of equipment.

Information on the membership picture and its implications is being prepared for the Spring

issue of *ANA in Review* which goes to every member of the Association

E.S. Conferences Planned: A one-day conference on the economic security program designed for SNA Boards of Directors is being made available to states on request.

Under the plan, one or two ANA staff members or members of the ANA Committee on Economic and General Welware will conduct or participate in the conferences, and it is suggested that a conference in a state be scheduled to coincide with a regular meeting of the SNA Board in order to keep expenses to a minimum.

The ANA Board, which made the service available through action at its January meeting, wishes all SNA's to have the opportunity to avail themselves of the service.

A memo being sent to SNA's this week gives specific information about this service and includes a form for use in requesting it.

The memo notes that not all SNA's will wish to request the service in 1961 and it would not be possible to fill requests from all 54 constituents this year. SNA's are asked to return the form as soon as possible so that conferences to be held this year can be planned on the basis of all requests received.

Convention Plans Underway: Preliminary plans for the 1962 ANA Convention, approved by the Board, call for general sessions on ethical and legal considerations in the regulation and improvement of standards of nursing practice, economic and general welfare, functions and relationships of the R.N., and the practical nurse, and disaster nursing. The convention will be held May 14-18, 1962, in Detroit.

A new feature to be planned for the 1962 convention will be two half days of clinical sessions. Tentative plans call for 20 simultaneous sessions to be held on each of the days designed to meet the clinical needs and interests of nurses in all areas of practice.

Appropriations To Be Requested: The ANA will support 1961-62 appropriations of $6 million for long-term and $600,000 for short-term courses under the professional nurse traineeship program, and $2 million for public health nurse traineeships under the program for professional public health personnel.

The traineeship program, passed by Congress in 1956 and renewed in 1959 for an additional five-year period, requires Congressional action each year as to the amount of appropriations.

In its report to the Board, the Committee on Legislation also outlined plans for the ANA Conference on Legislation to be held March 22-24 in Washington, D. C., for SNA representatives concerned with legislative programs.

A release on program and speakers will be sent to SNA's in the near future.

Delegate Representation Studied: The Board heard a report on extensive work done by a special committee appointed last year to study delegate representation.

The committee reported that numerous formulas had been considered in efforts to work out a practical approach to delegate representation that would be equitable and take into account variations in the total membership size of constituent states.

A plan proposed by the committee is based on both total active membership and the active membership of state sections; it retains section representation of all groups within the ANA.

The Board voted to confer with SNA representatives about the plan at the scheduled June meeting.

AJN Co. Asked to Explore Nursing Index: The ANA Board will request the American Journal of Nursing Company to explore ways and means of developing an index of nursing literature. This was decided following discussion of a communication from the Interagency Council of Library Tools for Nursing which cited "a growing and urgent need for an index to the nursing literature . . ." The Interagency Council was established last year to provide an opportunity for interested agencies to meet and discuss increasing needs for research and reference materials in nursing.

The ANA Board voted to ask the American Nurses' Foundation to explore ways and means of conducting an abstracting service in studies in nursing.

DEAN ARTHUR R. KELLER
1873-1961

Arthur Ripont Keller, dean emeritus of the University of Hawaii College of Applied Science and guiding spirit of engineering education development in Hawaii died at Queen's Hospital after a long illness—at the age of 78.

Dean Keller was vice president of the University when he retired in 1947. He was an honorary member of the Hawaii Nurses Association and gave many hours of time and effort to further the interests and educational opportunities of nurses.

Dean Keller, who lived at 2456 Oahu Avenue, is survived by his wife, Mrs. Lora Keller, and a sister, Mrs. William Mathieson, of Buffalo, N. Y.

Educators, Administrators, Consultants, Teachers

REVISED RULES

Approved by EACT Executive Committee, November 1960

RULE 1—Name

The name of this section shall be the Educational Administrators, Consultants, and Teachers Section of the Hawaii Nurses Association.

RULE 2—Objectives

The object of this section shall be:

Section a. To promote better nursing care of the public through consideration of problems related to the practice of nurses in the field of nursing education.

Section b. To support and promote the aims and program of the Hawaii Nurses Association.

RULE 3—Functions

The functions of the section shall include the following:

Section a. to define qualifications for membership which are consistent with the general membership requirements of the HNA.

Section b. To make rules for the government of the section provided these shall in no way conflict with the by-laws of the HNA, and shall be approved by the board of directors.

Section c. To cooperate with and assist the ANA section in defining and interpreting the functions, standards, and qualifications for practice of the educational administrators, consultants, and teachers, and others as recommended by the ANA Section Executive Committee.

Section d. To initiate studies or experiments for the improvement of practice within the field in relation to the overall purpose of the HNA, and the American Nurses' Association.

Section e. To study the general welfare and economic needs of the members and develop desirable standards of employment.

Section f. To organize subunits within the section, on request, in order that groups which have like interests shall have the opportunity of meeting to consider the economic security program separately from other groups in the same section whose economic interests might be somewhat different. The subunits shall have the privilege of reporting directly to the board of directors of the HNA.

Section g. To represent the interests of its members in meetings of the association.

Section h. To develop relationships with allied professional groups for conferences or committee work related to the objectives of the HNA.

Section i. To conduct programs of special interest to the members of the section and to participate with other sections that have similar interests.

Section j. To organize upon request, branches within the section for particular areas of practice, and conference groups between sections for special interests.

Section k. To develop and actively promote a program for intergroup relations within the section.

Section l. To plan a program of work and prepare an appropriate budget, annually, for presentation to the Committee on Finance of the HNA.

Section m. To make pronouncements in the name of the section, provided these pronouncements are not in opposition to the policies accepted by the HNA, and do not purport to represent the policies of the association as a whole.

Section n. To interpret all policies accepted by the HNA that affect the section and to publish these policies in the name of the section.

Section o. (1) To keep open direct channels of communication with the Educational Administrators, Consultants and Teachers Section of the American Nurses' Association, and to submit simultaneously copies of such communication to the Executive Secretary at state and ANA headquarters.

(2) To keep open direct channels of communication with the Educational Administrators, Consultants, and Teachers Sections of district associations, and to submit simultaneously copies of such communications to the presidents and executive secretaries (or elected secretaries of the district associations.

Section p. To elect delegates to biennial conventions and special meetings of the ANA in conformity with Article IX, Section 2 (a) of the By-Laws of the ANA, and Article IX, Section 7 of the HNA.*

RULE 4—Membership

Members of the Hawaii State Nurses Association who hold positions concerned with nursing education or research in nursing education, or who held such positions at the time of retirement, are eligible for membership in this section.

RULE 5—Officers

Section a. The officers of this section shall be a chairman, a first vice chairman, a second vice chairman, and a secretary, each of whom shall be actively engaged in nursing education at the time of election.

Section b. The regular term for all officers shall commence at the adjournment of the annual meeting at which they are elected.

RULE 6—Duties of Officers

Section a. The chairman (1) shall serve as a member of the Board of Directors of the SNA, preside at all meetings of the section, the executive committee and the advisory forum, and be an ex-officio member of all committees except the committee on nominations.

(2) shall represent the section on the Advisory Forum of the Educational Administrators, Consultants, and Teachers Section of the American Nurses' Association.

(3) shall be authorized to appoint any special committee necessary to further the work of the section, subject to the approval of the Executive Committee.

Section b. The first vice chairman shall perform the duties of the chairman in her absence, shall become the chairman in case of vacancy in that office, and shall assume such duties as may be delegated to her by the Executive Committee.

Section c. The second vice chairman shall become the first vice chairman in case of a vacancy in that office and shall assume such duties as may be delegated to her by the Executive Committee.

Section d. The secretary shall keep the minutes of all meetings, a copy of which shall be furnished the secretary of the HNA within two weeks following each meeting. The secretary shall write to the chairman of the district sections for Educational Administrators, Consultants, and Teachers prior to the annual convention asking for suggestions for committee members for the work of the state section.

Section e. All officers will make available to their successors all pertinent section material within two weeks after termination of office.

RULE 7—Executive Committee

Section a. There shall be an Executive Committee which shall consist of the chairman, the first vice chairman, the second vice chairman, the secretary, and two members-at-large elected as hereinafter provided. (Rule 13)

Section b. Regular meetings of the Executive Committee shall be held immediately preceding and immediately following the annual convention of the HNA at the place where such convention is held, and at such other time as shall be determined by the Executive Committee.

Section c. Special meetings of the Executive Committee may be called by the chairman on five days notice to each member either personally or by mail or by telegraph and shall be called by the chairman in like manner upon the request of not less than three members of the Executive Committee. Special meetings shall be held at such time and place as may be specified in the notice.

Section d. In intervals between regular meetings of the Executive Committee, the chairman of the section may refer and submit to the members of the Executive Committee definite questions relating to the affairs of the section which require immediate action. The result of such referendum shall control the action of the Executive Committee and shall be reported at the next meeting of the committee and recorded in the minutes.

Section e. Absence without good cause from three meetings of the Executive Committee shall constitute a resignation from this committee. Such vacancies shall be filled as hereinafter provided.

Section f. Absence of the section chairman from two meetings of the Board of Directors of the SNA, without good cause, shall constitute a resignation from this committee. Such a vacancy shall be filled as previously provided.

Section g. Absences wtihout good cause shall be determined by the Executive Committee.

RULE 8—Duties of the Executive Committee

The Executive Committee shall:

Section a. Appoint all standing committees except the committee on nominations and approve the appointment of all special committees.

Section b. Prepare the annual budget and provide for the expenditure of funds.

Section c. Review report of expenditures periodically.

Section d. Implement all functions of the section as set forth in these rules.

Section e. Consider and act upon requests for organization of branches, and subunits within the section and conference groups between the sections for special interests.

Section f. Fill any vacancies occurring on the committee on nominations and on the Executive Committee except that of chairman and first vice chairman.

Section g. Be responsible for guidance of the section in the achievement of its objectives and the coordination of its activities.

Section h. Transact the general business of the section in the interim between regular meetings.

Section i. Act in an advisory capacity to districts in all section problems referred to this section of the HNA.

Section j. Develop relationships with other sections of the HNA, and with departments of the Hawaii League for Nursing for conferences or committee work relating to mutual problems.

Section k. Receive and review reports of section committees, branches, and conference groups and make appropriate recommendations to the Board of Directors of the SNA.

Section l. Approve minutes of previous Annual Meeting immediately following the Annual Meeting.

RULE 9—Committees

Section a. Standing committees shall be composed of at least three members of the section, and shall assume such duties as shall be specified in these rules, and such other duties as may be assigned to them by the executive committee. Only active members shall be chairmen of standing committees.

Section b. The following standing committees (with the exception of three members of the Committee on Nominations who shall be elected as hereinafter provided), shall be appointed after each convention and shall serve until their respective successors are appointed: (1) Committee on Functions, Standards, and Qualifications for Practice. (2) Committee on Nominations (elected). (3) Committee on Program. (4) Committee on Rules.

Section c. The Committee on Functions, Standards, and Qualifications for Practice shall cooperate and assist the corresponding committee of the EACT section of the ANA to define and interpret the functions, standards, and qualifications of practice within the various fields of nursing education. It shall guide and direct the work of the corresponding committee of the district sections for educational administrators, consultants, and teachers. This committee shall be composed of active members only.

Section d. The Committee on Nominations shall consist of three active members of the section who shall be elected as hereinafter provided. This committee shall prepare a ticket for the section for each (annual) convention. This ticket shall consist of the names of two or more members of the section, who have consented to serve if elected, for each office to be filled, including Executive Committee members-at-large and members of the Committee on Nominations. No nominee shall appear on the ballot if election could result in concurrent membership on the Board of Directors or Committee on Nominations of the SNA or any other state nursing organization or on the steering committee of the divisions of the State League for Nursing.

Prior to the preparation of such a ticket, and at least six months before the scheduled date for the (annual) convention, the chairman of the Committee on Nominations shall request from the district sections of Educational Administrators, Consultants and Teachers a list of names of persons qualified to fill vacancies in these offices.

In preparation of the ticket, the Committee on Nominations shall give consideration to: (1) Qualifications of candidates. (2) Distribution in special fields of interest. (3) Geographic distribution. (4) Names suggested by the largest number of districts.

The Committee on Nominations shall send the ticket of the EACT Section to the headquarters of the Hawaii SNA in such time that the ticket can be sent to the district nurses' association at the same time that the ticket of the Hawaii SNA is sent to them.

The ticket shall be presented to the members of the section at its first business meeting during the (annual) convention, at which time nominations from the floor may be added.

In the odd years the committees on nominations shall also prepare a ticket for the election of delegates and alternates for these delegates, to the ANA Convention to be held in the next even year.

Section e. The Committee on Program shall receive suggestions from districts for programs and shall prepare programs for the regular meetings of the section. It shall submit the section's program for the annual meeting to the chairman of the committee on program of the HNA at a time designated by the chairman of the Committee on Program of the HNA.

Section f. The Committee on Rules shall review the present rules, receive and consider proposed amendments and make recommendations to the executive committee. This committee shall upon request of a district section review district rules and make recommendations to district sections.

RULE 10—Subunits

Section a. Subunits shall be organized on request within the section in order that groups which have like

interests shall have the opportunity of meeting to consider the Economic Security Program separately from other groups in the same section whose economic interests might be somewhat different. Such subunits shall have the privilege of reporting directly to the Board of Directors of the HNA. The functions of a subunit shall be to: (1) Adopt employment standards for its members. (2) Cooperate with the HNA Board of Directors in the implementation of these standards. (3) Serve in an advisory capacity in all matters affecting the economic welfare of its members.

The officers of a subunit shall be a chairman and a secretary, each of whom shall be actively engaged in nursing education at the time of election and who shall be elected annually by members of the subunit.

Section b. A subunit Committee on Employment Conditions, composed of the chairman of the subunit and at least two active elected members of the subunit, shall be formed as soon as subunits are established. This committee: (1) Shall prepare tentative employment standards, or revise existing standards. (2) Shall present standards to the subunit membership for consideration and adoption. (3) May transact business of an urgent nature, pertaining to standards, between subunit meetings. All transactions of this committee shall be reported in full at the next regularly scheduled meeting of the subunit.

RULE 11—Advisory Forum

Section a. The Executive Committee of this section and the chairman of the district sections for Educational Administrators, Consultants, and Teachers shall constitute an advisory forum to consider and promote the interests of the Educational Administrators, Consultants, and Teachers Section of the HNA.

Section b. In the absence of the HNA, chairman, either the first vice chairman, second vice chairman, secretary, or some other active member of the section, appointed by the district chairman, shall act in her capacity.

Section c. Meetings of the advisory forum shall be held in connection with each annual convention as provided for by the committee on program of the Educational Administrators, Consultants, and Teachers Section of the HNA.

RULE 12—Voting Body

The voting body at any meeting of the Educational Administrators, Consultants, and Teachers Section shall consist of the active members of the section who are in attendance and have submitted identification as active members of the section.

RULE 13—Elections

Section a. A chairman, a second vice chairman, and one member-at-large of the Executive Committee shall be elected in the even years to serve for two years or until their successors have been elected. A first vice-chairman, a secretary, and one member-at-large of the Executive Committee shall be elected in the odd years to serve for two years or until their successors have been elected. Three members of the Committee on Nominations shall be elected to serve until their successors have been elected. Election of officers and voting on amendments shall be upon identification of voters as members of the section.

Section b. Election shall be by secret ballot at the time and place provided for the election by the HNA.

Section c. A plurality vote of the members of the section present, entitled to vote and voting, shall constitute an election.

Section d. At the first business meeting of the section at the annual convention, the chairman shall appoint tellers.

Section e. No member shall serve more than two consecutive terms in the same office; the period of consecutive service on the Executive Committee shall not exceed eight years. A member who has served more than one-half term shall be deemed to have served a full term.

At conventions held in odd years, delegates shall be elected to serve as representatives of the SNA to the ANA Convention to be held in the next even year. Alternates for the delegates shall also be elected.

All ballots and other records of the election shall be preserved for one year after the election.

RULE 14—Meeting

Section a. This section shall meet at such time and place as shall be recommended by the section, and approved by the Executive Committee of the section.

Section b. Section officers shall be elected at an annual meeting which shall be held either at the time and place of the annual convention or preceding the convention. Such slate of officers to be presented at the house of delegates. Officers elected prior to the annual convention will not take office until after the convention.

Section c. Business meetings shall be open to members of the section and guests, unless otherwise voted. Nonmembers, if admitted, may have voice but no vote.

RULE 15—Order of Business

The order of business at annual meetings shall be:

(1) Roll call
(2) Report of Committee on Nominations
  (a) Completion of Ticket
  (b) Introduction of Candidates
(3) Appointment of Tellers
(4) Report of the Chairman of the EACT Section of the HNA
(5) Reports of other standing committees:
  (a) Report of Committee on Functions, Standards and Qualifications for Practice
  (b) Report of Committee on Program
  (c) Report of Committee on Rules
(6) Reports of special committees
(7) Reports of branches and conference groups
(8) Reports of chairmen of the Educational Administrators, Consultants, and Teachers sections of district nurses' association
(9) Unfinished business
(10) New business
(11) Report of Tellers and introduction of new officers
(12) Reading of minutes for correction
(13) Adjournment

RULE 16—Quorum

Section a. A quorum at any meeting of the section shall consist of one officer, and members present, and entitled to vote and voting.

Section b. A quorum at any meeting of the Executive Committee shall consist of a majority of the members.

RULE 17—Amendments

Section a. There rules may be amended at any (annual or biennial) meeting by a two-thirds vote of the members present, entitled to vote and voting, provided the proposed amendments have been approved by the Board of Directors of the HNA and have been appended to the call of the meeting.

Section b. These rules may be amended without previous notice at any (annual) meeting by a 99 percent vote of the members present, entitled to vote and voting, and become effective after approval by the Board of Directors of the HNA.

HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

CAROLYN E. MCCUE, *Editor* BERYL UYEHARA, *Associate Editor*

*What's New in Hematology**

Research in hematology has made great strides in the last few years. Many of our concepts have been completely revised or at least modified. For example, 15 years ago we were satisfied to establish a diagnosis of anemia when decreased numbers of red blood cells were found in the counting chamber. Today we consider a low red-cell count only a first finding which has to be followed up. We now not only determine the hematocrit and hemoglobin values, but also measure red cell mass, estimate the reticulocyte level, determine the serum iron and the iron-binding capacity, the kinetics of radioiron, the survival time of radioactive red cells, the different possible auto-immune gamma globulins, and dynamics of bone marrow, and so on. New tests appear every day in the literature. In this race for better understanding of diseases, we have to decide which tests are here to stay and which are presented only for the sake of appearing in print.

Despite this constant state of confusion, there are many fields in hematology in which definite progress has been made in the last year. For the sake of brevity I shall discuss here only those few advances which are based on sound and rather simple laboratory tests. I am sure that many of these newer concepts are not new to most of you, and that you are also familiar with the techniques involved.

Red Blood Cells

Today the diagnosis of anemia is made much more frequently than it was ten years ago. This is chiefly because laboratory methods have been vastly improved. Consequently, it is now possible to diagnose mild anemias. I am sure most of these cases remained undiagnosed in the past, since a 15-20 per cent decrease of hemoglobin or total red-cell count was within the range of normal in the techniques formerly used.

The number of circulating red cells depends on two processes: (1) bone marrow activity, producing red cells; and (2) the rate of loss or destruction of red cells. In the diagnosis of anemia, of course, it is important to determine whether the cause is slow production, accelerated destruction or *loss*.

One of the easiest tests in such cases is the determination of reticulocytes. We know that all the reticulocytes in the peripheral blood must be less than 1 day old. Knowing then, that all these cells were released from the bone marrow during the past 24 hours, good bone marrow activity is assumed in the presence of an increased number of circulating reticulocytes. You all test for these young red cells every day in your laboratory. In the first approximation, this statement is correct and the reticulocyte count is a time-honored procedure. However, recent studies clearly indicate that, under normal circumstances, the bone marrow releases only mature red cells, without reticulum.

The evidence for this is obtained by the following procedure: Radioactive substances are injected into patients, and blood samples taken a few hours later clearly indicate which cells were produced after the administration of the radioactive tracer. Red cells containing radioactivity could not be older than a few hours, yet most of them were not reticulocytes. Therefore a new concept had to be developed, since it was obvious that the number of recently-produced red cells might be much higher than the number of reticulocytes. At present it is generally accepted that in an equilibrium between bone marrow and peripheral blood, most of the red cells entering the circulation are not reticulocytes. If however, there is a loss of red cells; e.g., from bleeding or hemolysis, the bone marrow will attempt to replace the destroyed or lost cells, and will release mainly reticulocytes. This is a very complex process.

We have learned a great deal about the process of red cell production in the last few years. Radioactive isotopes are a very effective means of studying the dynamics of bone-marrow activity. Two of the radioisotopes seemed to be especially useful in clinical hematology: radiochromate and radioiron. Chromium ions have a very high affinity for the hemoglobin molecule. If red cells are exposed to a radiochromate solution, the chromium ions will become firmly and permanently attached to the hemoglobin molecule in the red cells. This labeled blood is then reinjected into the circulating blood of the patient, where the marked radioactive red cells will soon be evenly distributed among the other circulating cells. Subsequently, blood samples will be collected from the patient at intervals and the survival time of the reinjected erythrocytes determined. In hemolytic disease, as well as in cases of hemorrhage, the faster disappearance from the vascular bed of the injected radioactive cells is a quantitative measure of red-cell loss.

Other important information can be obtained by this technique. For example, in hemolytic diseases, the role of the spleen in the destruction of red cells may be determined by scanning over the abdominal skin of the patient. If radioactivity is considerably higher over the spleen than it is over the liver, we have proved that the red cells are destroyed in the spleen. Consequently, we can expect splenectomy to be effective in curing the patient.

Still another excellent use of radio-chromate-labeled red cells is in demonstrating bleeding. Another radioisotope, which is being used extensively in hematologic research but less in clinical hematology, is radioactive iron. Recent studies suggest that the rate of red-cell synthesis can be very accurately measured with radioiron, and surprisingly exact calculations can be made concerning the amount of hemoglobin produced in unit

* Excerpts taken from an article by Elemer R. Gabrieli, M.D., Director, Clinical Laboratories, Millard Fillmore Hospital, Buffalo, New York. Reprinted in part, with permission, from *The Journal of the Empire State Association of Medical Technologists.*

time per unit volume of bone marrow. The use of radioiron is, however, at present limited to research laboratories.

A giant step forward was made when it was discovered a few years ago that hemoglobin in sickle-cell disease moves electrophoretically slower than does normal hemoglobin. This observation opened up a large field. It was postulated that if there is an electrophoretically demonstrable difference, there also must be a chemical difference between normal and sickle-cell hemoglobin. Very rapidly, then, more and more abnormal hemoglobins were found, until today 29 different hemoglobins are described in the literature.

In this brief discussion, space does not permit me to review other fields of hematology in which major advances have been made. However, in conclusion, I wish to emphasize the importance of keeping up with developments in laboratory medicine. There is a lag of from three to five years between discoveries made in research laboratories and their practical utilization in the diagnostic routine. Within the past few months two new tests for demonstrating specific antibodies in lupus erythematosus appeared in the literature. I am afraid it will be four or five years before their usefulness will be established.

The medical technologist carries a great deal of responsibility in a clinical laboratory. Not only the everyday routine work has to be done, but time must be found to keep up with newer tests. Successful scientists are the glamorous heroes of research, but successful developments in the field of laboratory medicine depend equally on your willingness to try new tests and transplant them to routine laboratories.

*Experiences with the Caraway Method for Amylase**

In suspected cases of acute pancreatitis, emergency amylase determinations are frequently requested. We had been using the five-minute incubation Somogyi method, based on amyloclastic activity and a color reaction with iodine. However, individual differences and difficulty in the visual reading of the endpoint were encountered, with resulting inaccuracies and time-consuming repeats. We decided to try the Caraway method which was also based on a color reaction with iodine but used a stable, buffered starch substrate and measured the final color in any spectrophotometer.

Reagents were prepared according to the instructions given in the publication. To avoid contamination, the starch substrate was dispensed into three-ounce bottles. Since the starch solution is stable at room temperature, only one bottle at a time was kept out for daily use and the remainder stored in the refrigerator. The procedure was modified slightly by using half volumes of reagents and specimen. Test tubes graduated at 25 ml were used for the incubation stage. This modification was made due to the tendency of the 50 ml volumetric flasks (specified in original procedure) to float around in the water bath, necessitating impractical preparations, to hold them in place.

Amylase determinations were done on more than 50 serum specimens. The normal range was found to be the same (60 to 160 units) as that originally reported. High values were relative to Somogyi method results for the same specimens. Commercial enzyme standards assayed were found to give results in the acceptable range. Low values were not reproducible, as reported by Caraway.

No normal urine amylase range was given in the original report. The recommended 1-hour or 24-hour urine collection was regarded as impractical. Instead, random urine specimens were tested and a normal range of up to 500 units was established for this laboratory.

If the amylase activity exceeded 400 units, the test was repeated using a 5-fold dilution of specimen with 0.9 per cent sodium chloride. This dilution was usually adequate for serum but urine specimens were sometimes diluted 10-fold.

We had fairly good results with the one or two peritoneal fluid specimens submitted for amylase determinations. This was due to the buffer system present in the starch substrate. However, we hope to do more studies on body fluids.

In summary, a rapid and simple method for the determination of amylase in serum and other body fluids has been tried. With a slight modification, it has been found practical and accurate. The stability of the starch solution eliminates frequent and tedious preparation.

LORENE LEONG, M. T. (ASCP)†

News Notes

February's meeting featured Dr. Harry Silver of the University of Colorado, the visiting professor at Children's Hospital. He spoke on "Urinary Cytology" and "Some Endocrinological Studies Applied to Laboratory Diagnostic Procedures." The Finance Committee announced the start of the candy sale to raise funds to send a convention delegate and to help defray expenses of the 1961 Post Convention.

There was no speaker for the March meeting. Discussion of financial expenditures, delegates, and scholarship setup was carried out.

At the April meeting, a film titled "Some Techniques of Tissue Preparation in the Pathology Laboratory" was shown.

The annual meeting on May 9 included a dinner, reports by various committees, and final discussion on unfinished business.

* Technical Bulletin of Reg. of Med. Tech. Vol. 29, No. 6, June 1959.

† Department of Laboratories, The Queen's Hospital.



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HAWAII PHARMACISTS' BULLETIN

Official Publication of the Hawaii Pharmaceutical Association

Legislative Committee Report

Every year there is much legislation pertaining to business and to our profession. This year we have had good coverage on checking adverse legislation so far. Cooperation among the physicians, dentists, and pharmacists on pertinent matters has been excellent, and because of this cooperation, we have been able to work hand in hand to get legislation that we want.

As always it is a nip and tuck affair whenever our legislators meet. We feel now more than ever that each one of us as a professional man should in some way participate and take active interest in politics; especially with legislation concerning regulation of our profession. Support from a united front carries a lot more meaning to our legislators.

The 1961 Legislature is now a thing of the past, but we must be prepared for the next one. At that time there will be new challenges that must be met.

We, as professional men, should think seriously of our profession. Whenever there is an opportunity to improve our profession, we must think and act constructively to do so.

Thank you very much to all those that helped in our last legislature, and to those that were not able to help, may you be participating with us in the next session.

WILLIAM K. HAINA

Convention News

The Fifth Annual Hawaiian Pharmaceutical Convention was held at the Reef Hotel, May 17 to 20. The steering committee which planned the program consisted of the following persons:

William K. Haina, Jr., President, Hawaii Retail Druggists Association
Warren Jung, President, Hawaii Pharmaceutical Association
Jacob Y. Kim, Vice-President, Hawaii Retail Druggists Association
Herman Wat, Vice-President, Hawaii Pharmaceutical Association
Emma Look, Secretary, Hawaii Pharmaceutical Association
Albert Miyamoto, Treasurer, Hawaii Retail Druggists Association
Robert Masui, Treasurer, Hawaii Pharmaceutical Association
Henry Urashima, President, Medical Service Representatives of Hawaii
Charles Malang, American Factors, Ltd., Drug Department
William C. Koch, Theo. H. Davies & Co., Ltd., Drug Department
Leon Long, McKesson & Robbins
Ed Weidknecht, Von Hamm-Young Co., Drug Department.

The presidents of the Hawaii Pharmaceutical Association and the Hawaii Retail Druggists Association served as general co-chairmen of the convention; Warren Jung as chairman of the finance committee and William Haina as chairman of the program committee. Jim Patterson again served as executive secretary.

Pharmacists in the News

Kenneth Lum, chairman of the Board of Pharmacy, left on April 22 to attend the 108th meeting of the American Pharmaceutical Association. He also attended the meetings held by the National Association of Boards of Pharmacy. **Vern Jowers** (Schering) and **Earl Sandison** (Mead Johnson) have also taken trips to the Mainland in April. **Mr. and Mrs. Sidney Kosasa** left on Saturday, April 22, for a six-week tour of the Orient which included visits to such exotic places as Hong Kong, Singapore, Cambodia, Manila, Bangkok, Tokyo, and Kuala Lumpur. **Sidney Kosasa** is Secretary of the Board of Pharmacy. Another pharmacist who left in April for a tour of Europe is **Mrs. Matsuyo Machida,** mother of pharmacists **Richard** (Kapahulu Drugs) and **Gene** (Longs Drugs). **Richard Machida,** incidentally, is serving as a director of Pacific Laboratories, which opened recently.

Ben Tadano, formerly chief pharmacist at The Queen's Hospital, is now a 2d Lieutenant in the Air Force. **Andrew Oshiro** is now in charge of the pharmacy department at Queen's. **Wilfred Inoue** is the new Lilly representative. A graduate of the University of Michigan, he was formerly pharmacist at Longs Drugs. St. Louis Pharmacy is the name of the new drug store which will be opened in July according to **James Asato,** former Lilly representative. **Samuel Ching** is at present manager of Sav-Mor Moanalua. **Mrs. Katherine Chow** is away on a leave of absence. New manager at Sav-Mor Kapiolani is **Richard Meguro.**

The following have successfully passed the examination given by the Board of Pharmacy on April 12 and 13:

Willis F. De Vaney—A native of Oregon, Dr. De Vaney is a graduate of Oregon State College, and holds the degrees of Ph.C. and D.O.

Noel Dean Evans—Originally from Iowa and a graduate of University of Iowa, Mr. Evans is staff pharmacist at St. Francis Hospital.

Florence S. Frick—Chief pharmacist at St. Francis Hospital, Mrs. Frick is registered also in the states of New Jersey and New York. She is a graduate of Rutgers College of Pharmacy.

Joyce M. Holland—A pharmacist at Waipahu Professional Drugs, Mrs. Holland is originally from Ohio.

Wallace G. Kirkman, Jr.—A native of Utah and a graduate of Idaho State College, Mr. Kirkman holds registration in Utah and Idaho.

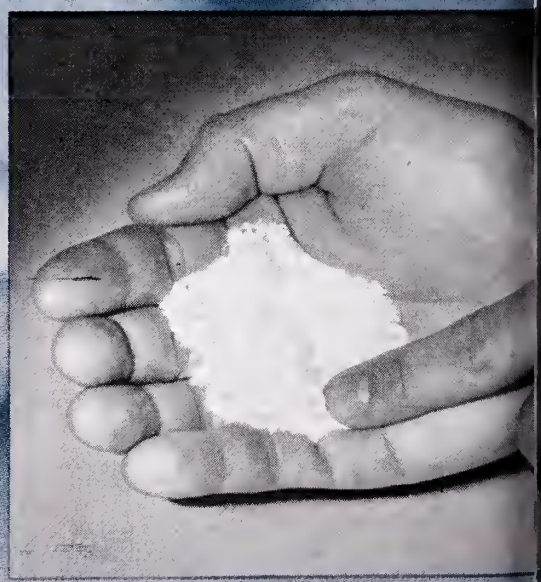
Richard Meguro—At present manager of Sav-Mor Kapiolani, Mr. Meguro is a graduate of University of Southern California.

Don Westlake Meloan—A graduate of Ferris Institute, Mr. Meloan is staff pharmacist at Kaiser Hospital. A native of Illinois, he holds registration in that state also.

Charles William Thompson, Jr.—A medical service representative for Massengill, Mr. Thompson is from Texas and is a graduate of the University of Texas.

Omel L. Turk—A graduate of University of Washington, Mr. Turk is currently associated with the Medical Group.

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HAWAII MEDICAL ASSOCIATION

(Continued from page 459)

King bill would not pass this year or next. However, at the meeting it was brought out that now is the time for the physicians to sit down and talk to their friends in the community in order that the measure can be defeated. Dr. Nishigaya said he plans to meet with members of the Woman's Auxiliary and with Mr. Lytle to work out a program in order to get some action on this. In a straw vote taken at the meeting the results predicted for the House of Representatives was 220 against the Social Security approach, 133 for, and 75 questionable. In the Senate 46 of the senators are thought to be in favor of medicine's viewpoint and 42 against with 10 considered questionable.

Dr. Cushnie thanked Dr. Nishigaya for making the trip and for his excellent report. Dr. Moran suggested that we include the names and addresses of the Congressmen when we circulate the membership so that the doctors will know how to address their letters.

BRONZE PLAQUE

This item on the agenda was not discussed.

POISON PAMPHLETS

Dr. Cushnie noted that the original 50,000 pamphlets which were sent by the AMA, without cost, except for shipping charges, were all distributed through the Woman's Auxiliary in Honolulu and the requests for supplies for the other islands were not filled. After a separate order was placed for 3,000 each for Kauai and Maui and 6,000 for Hawaii, the AMA advised the response had been so great they had been compelled to place a charge of 1 cent each on the pamphlet. A discussion followed on how these charges should be handled. Dr. Brennecke wondered if there were a need for these pamphlets. Dr. Burden questioned the $5.00 allotment out of the HMA dues for the Woman's Auxiliary. He was advised that this is for the state auxiliary only, except that $1.00 is passed on to National.

ACTION:

It was moved and seconded that the Woman's Auxiliary to the Hawaii Medical Association estimate the total cost of the 62,000 pamphlets and that the various county societies be asked to assume their proportionate share of the cost. The motion passed unanimously.

SECRETARY'S REPORT

Dr. West read the Secretary's Report which had been circulated. On December 31, 1961, there were a total of 539 regular, 28 life, 2 military, 38 associate, 3 retired, and 9 honorary members. In January Kauai County elected Jay M. Kuhns to life membership; Honolulu elected Alvin A. C. Paraz to active membership and deleted John R. Brown, Christopher Bull, and Merle S. Mark from their roster as these doctors had moved out of the state; Drs. Beverly Jeanne Burdette and Frank E. Glaser were dropped for nonpayment of dues. In February Honolulu elected Arthur J. Okinaka, Clarence S. Sakai, and David A. Sinclair to regular active membership; transferred Raymond Dusendschon from active to associate membership; and deleted Walter B. Herter from its roster in anticipation of his move to Kauai. Maui's active membership was reduced to 33 during

(Continued on page 482)

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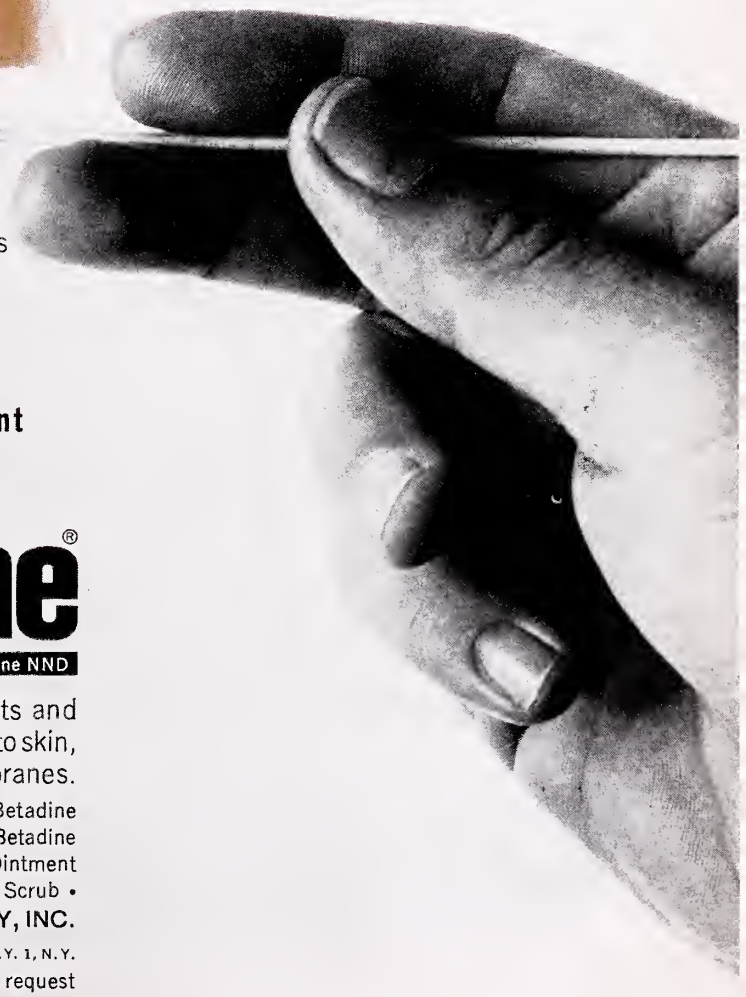
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HAWAII MEDICAL ASSOCIATION

(Continued from page 480)

February by the death of Dr. Charles Price. Therefore, as of the last reporting period, February 28, 1961, the total membership of the HMA was 612. Dr. Nishijima asked at what age the members of the neighbor island doctors were made life members and whether it was based on the length of service or their age. Dr. West explained that this varied with the county. Dr. Goodhue said that a doctor on Kauai isn't made a life member until he actually retires.

ACTION:

It was moved and seconded that the dues of Jay M. Kuhns be waived and that he be made a life member. The motion passed unanimously.

The question of whether life members receive the JOURNAL was raised and answered negatively.

ACTION:

It was moved and seconded that Drs. Alvin A. C. Paraz, Arthur J. Okinaka, Clarence S. Sakai, and David A. Sinclair be accepted as regular active members; that Dr. Raymond Dusendschon's status be changed from active to associate; and that Drs. Christopher Bull, Merle S. Mark, Beverly Jeanne Burdette, and Frank E. Glaser be removed from the roster. The motion passed unanimously.

It was moved and seconded that the Secretary's Report be accepted. The motion passed unanimously.

AUDITOR'S REPORT

The following auditor's report was read by Dr. Giles:

I have examined the accompanying statement of assets and liabilitie of the Hawaii Medical Association as of December 31, 1960, resultin from cash transactions, and the related statement of cash receipts an disbursements on account of income and expenses for the year the ended. My examination was made in accordance with generally ac cepted auditing standards, and accordingly included such tests of th accounting records, and such other auditing procedures as I considere necessary in the circumstances.

The books were maintained on a "cash basis," i.e.: income wa recorded as such when received, irrespective of when it was earned and the expenses were so recorded when paid, without regard to whe the liability was incurred.

"Other assets" in the amount of $269.00, as listed on the statemen of assets and liabilities, included the amount of $231.50 due fro the Golf Committee. This represented $157.26 in expenses incurred b the Golf Committee and charged to Hawaii Medical Association dur ing 1960, plus $74.24 of similar expenses incurred in 1959 and carrie forward as due from the Golf Committee. The minutes reflect n formal action authorizing the Golf Committee to incur such obliga tions and to charge them to the Hawaii Medical Association. Durin 1960, such monies as were received for the golfing activities supervise by the Committee were retained and disbursed by the Committe thereby removing them from the control of the Treasurer. It is sug gested that provisions be made in the 1961 budget for this item o $231.50, and that steps be taken to clarify the Council's intent wit respect to financing the activities of this committee.

A typewriter which was presented to Dr. Arnold, Editor of th Hawaii Medical Journal, was charged to "journal expenses." I coul find no authorization for this purchase in the amount of $134.89.

The propriety of the figures reflected by the book as "dues" incom could not be verified. As the organization's official minutes did no list the names of all new members and the amount of dues for whic they were liable, there was no way to compute the amount of due which should have been received as compared with the dues whic were recorded as received. The membership lists submitted by th County Societies listed 521 regular members at the end of 1959. Th records of the Hawaii Medical Association for 1960 showed that 51 members had paid dues in the amount of $35.00 each, an additiona 19 members had paid prorated dues in varying amounts, and 19 addi tional "regular members" had paid no dues at all. The situation wit respect to verification of "dues" income has deteriorated, although th problem, and the cure for it, has been commented upon previously.

Annual exhibitors' income in the amount of 3,800.00 included $100.00 fee collected from the Muscular Dystrophy Association o America, although other organizations of similar nature were no charged for exhibit space.

Annual meeting income could not be verified. The minutes indicat that 289 members registered for the annual meeting but the book

(Continued on page 484)

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HAWAII MEDICAL ASSOCIATION

(Continued from page 482)

show that only 272 members paid registration fees. I could find no record of formal action authorizing waiver of registration fees for anyone other than Dr. Harry L. Arnold. Accordingly, there was no way to determine whether or not the waiver of fees in other instances was proper. In checking the receipts issued for registration fees and other fees collected in connection with the annual meeting, I found that at least in two instances the amounts shown on the receipts did not agree with the amount of money deposited.

The Physicians' Benevolent Fund was established by contributions received from members in the aggregate amount of $3,875.00 during the last four months of the year. Of these monies, $2,305.00 was placed on deposit with the American Savings and Loan Association where it earned interest during the remainder of the year. $1,570.00 was deposited in the Bank of Hawaii commercial account, where it was co-mingled with other funds and disbursed in payment of current operating expenses. All monies earmarked for the use of the Physicians' Benevolent Fund should be physically segregated in a separate account as were the $2,305.00. Such monies should be deposited directly to the separate account, promptly as received, and should not be withdrawn until formal authorization to do so has been granted.

A number of disbursements had no documentary support, and included among these were checks issued for payment of AMA convention expense, Council meeting expense, annual meeting expense and travel expense. Bills and receipts in support of petty cash disbursements were grossly inadequate. This was particularly disturbing in view of the indication of at least one cash shortage. Check number 1267, dated December 31, 1960, was issued in the amount of $70.00 to reimburse the petty cash. As the petty cash is a revolving fund in the amount of $50.00, this would indicate that the petty cash had been implemented through the advance of personal funds by employees. Such practice opens the door to many problems and should not be permitted.

The nature of the problems disclosed by my examination showed a lack of internal control which could not be compensated for by other audit procedures within the limits of reasonable cost. Therefore, I am unable to express an opinion as to the fairness of the representation of the accompanying statements.

FRANK R. HOUGH
Certified Public Accountant

Dr. Giles said that the report represented an indictment of our method of maintaining books, the system of banking, and the system of keeping various types of funds which we have under our control. It shows a lack of close check in our financial dealings and the administration of our organization, which should not be allowed to continue.

Golf Committee Deficit: Dr. Cushnie asked for questions and the several points of the report were taken up separately. The golf committee deficit was explained by Dr. Nishigaya who apologized to the Council for not bringing up the matter before since he had taken the responsibility for this. It was anticipated that the small deficit from 1959 would be taken care of in 1960 but unfortunately, due to a misunderstanding, the deficit was increased rather than decreased. Dr. Giles said he felt that this money should come under the control of the Treasurer. It was noted that this year the tournament fee, including the contribution, will become part of the registration form and will not be collected by the committee at the caddy house. Also that in an effort to correct the over-spending, the committee is not authorizing funds for pictures. Dr. Nishigaya said that he had a contingency fund of $1,000 out of which no charges were made. He authorized payment for several unexpected expenses covering the entertainment of AMA president and if he had authority to do that, he could assume authority for the HMA to assume the deficit. Dr. Cushnie thought Dr. Nishigaya was correct in assuming the responsibility but that we cannot keep on with a separate fund not under the control of our Treasurer.

ACTION:

It was moved and seconded that the golf machinations be placed under the treasurer during the coming year and that action on the present deficit be deferred until the outcome of the next golf tournament is known. The motion passed unanimously.

Typewriter: Dr. Cushnie explained that he authorized the gift of the typewriter to Dr. Arnold in view of his having worn out his own portable, and he thought that was the least the Association could do. It was noted that most pay their editors. The expense was charged to the JOURNAL.

ACTION:

It was moved and seconded that the Council approve of the President's action in authorizing the gift of the typewriter to the editor. The motion passed unanimously.

Collection of Dues: The dues problem was discussed at some length. Dr. Cushnie said that unless we follow the auditor's instructions we will be in the same boat next year. Dr. Giles asked if there were any way the Secretary could balance the books so that at every meeting when an individual is voted into or dropped from membership there would be a balance of "in" and "out" that should equal the income from dues. It was noted that this problem is being taken into consideration in the present revision of the bylaws.

ACTION:

It was moved and seconded that the Treasurer request from the several counties the names of their members and that the Council approve of the action of the several counties and the names they submit to us as of January 1, 1961. The motion passed unanimously.

Dr Cushnie advised that this subject had come up before. At its July 23, 1959, meeting, the Council declined to act individually on membership changes and moved to automatically waive the dues of members after similar action by a county society. If we had corrected the procedure at that time, we wouldn't be in trouble now. Dr. Giles said that if we want to keep our auditor, we must follow his instructions.


Dr. Steele Stewart

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ACTION:

It was moved and seconded that Dr. West look into the matter of dues reporting and report back to the Council at its next meeting. The motion passed unanimously.

It was noted that the Muscular Dystrophy Association, which is not a local voluntary health organization, asked for a booth and was therefore charged the usual rate. Local health organizations do not use booths.

Registration fee: The discrepancy between the number of registrants for the annual meeting and the money received is due to the waiver of this fee for guest speakers, interns, residents, nurses, etc., and this waiver is so noted on the sales slip made out for each registrant.

Travel Expense: The travel and per diem expenses were discussed. It was noted that in the past a check covering first class fares and a set amount for expenses has been given to the AMA delegates. Other official travel has been at a per diem rate. Up until this year the auditor had not requested an accounting of these expenses. In the 1961 budget all travel is on the tourist rate and a set sum for expenses has been superseded by per diem allotments. The Internal Revenue Department has made new rulings on how these expenses are to be reported. It was thought that further clarification on this subject was needed and Dr. Giles was asked to report back on it at the next meeting.

Benevolent Fund: It was explained that an apparent discrepancy in the accounting of the Physicians' Benevolent Fund is explained by the fact that the accounting for the HMA is on a "cash" basis and that the check transferring the money collected for this fund was drawn on the last day of the fiscal year and deposited to the special account in the American Savings & Loan Association January 10, 1961. At the end of the fiscal year, the checking account was practically depleted and rather than take money out of the savings account and lose interest, this transfer was handled in this manner. The Association had a check from the BME for $1800 covering 1961 JOURNAL subscription for Honolulu County members which would have shown additional income for the JOURNAL in 1960 and a deficit for 1961 had it been cleared in 1960. The overdraft shown in the accounting was an "paper" figure and not the actual balance in the checking account. The pass book showing the Physician's Benevolent Fund balance was shown to the members of the Council and was found to be in order.

Petty Cash: It was noted that the reason the $70.00 check for Petty Cash was drawn was to cover a $20.00 overdraft on that account occasioned by the necessity of the executive secretary's use of personal funds to buy stamps.

TREASURER'S REPORT

Dr. Giles submitted the budget and advised that the General Fund as of December 31, 1960, was $30,541.98, a net increase of $3,503.95 over the amount reported December 31, 1959. A transfer of $5,000 made from the checking account early in 1960 resulted in higher income from interest. Other items that appeared on the budget were discussed, and submitted for approval subject to the minor changes which will have to be made on the 1960 expense figures which were compiled before Mr. Hough completed his audit.

The Treasurer made the following recommendations:

(1) That the services of Mr. Frank Hough be retained

(Continued on page 486)



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HAWAII MEDICAL ASSOCIATION

(Continued from page 485)

at $200.00 for 1961 and that his recommendations be carried out.

(2) Mr. Hough has repeatedly requested that more careful reporting of membership changes be made and these recommendations have not been followed. The Council with the assistance of the Secretary should be made solely responsible for reporting and approving new members, changes in membership status, waiver of dues, and anything else which would effect the amount of money paid into the Treasury in the dues account.

(3) The JOURNAL subscription rate for 1962 should be increased from $4.00 to $6.00 and that when the next contracts with the Hawaii Nurses Association and the Hawaii Society of Medical Technologists are signed that they be given a 50% discount ($3.00).

(4) The annual dues for 1962 should be increased from $40.00 to $55.00 to include $15.00 for the public relations program and that charges applicable to this program be kept on a separate schedule. He further recommended that the consultant's fee be set at $6,000 for 1962 in accordance with the provisions outlined at the time he was engaged.

(5) Dues should be collected from each inactive member in order to cover the costs of keeping him on the roster and that these dues be set at $2.00 for 1962.

(6) Support of the Oahu Health Council should be dropped in view of the generous support given this organization by the Honolulu County Medical Society.

(7) The Council should consider implementing the decision made by the House of Delegates in 1956 as reported in the minutes published in the July-August, 1956, issue of the JOURNAL (page 579) whereby it was voted that $150.00 be raised for the Legislative Committee, ¾ of it to come from Honolulu County, during legislative years.

Dr. Giles advised that he had thought for a while that the HMA wasn't going to have the money it needed to run on. The expenses are increasing and the income does not go up in proportion. The present budget has been pared down as much as it could be. The committee made several suggestions such as asking the Woman's Auxiliary to help out by staging benefits, asking different firms who customarily give the doctors presents at Christmas time to donate to the Association. He said he felt the pinch this year and it is going to be more of a pinch in the years to come. Dr. Nishigaya said that the HMA is having the same experiences as every other organization and if we feel that we need the services, we should raise the dues instead of asking for money. He said he agreed with the Treasurer's report except that he did not feel that the support of the Oahu Health Council should be dropped. Dr. Allison concurred and said that he didn't think it would be good public relations for the Medical Association to withdraw support from an agency designed to improve health conditions. The Chamber of Commerce is the main supporter, with $5,000 annually.

Dr Allison questioned whether the Association should pick up meal and drink tabs for the Council. Dr. Burden noted that the men from the neighbor islands had to lose at least a half day in their offices in order to attend the meetings.

Dr. Giles amended his report to include continued support of the Oahu Health Council.

(Continued on page 488)



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HAWAII MEDICAL ASSOCIATION

(Continued from page 486)

ACTION:

It was moved and seconded that the amended Treasurer's report be accepted and submitted to the House of Delegates for final approval. The motion passed unanimously.

DUES

The matter of increasing the dues was discussed further. Dr. Benson thought we should be more realistic about this. Dr. Giles noted that our expenses are not going to go down and the only way we can get money is from dues. Dr. Allison wondered about the applicability of Parkinson's law. Dr. Giles spoke on the difficulty the Association had in keeping help. Dr. Moran said that a further increase in dues wouldn't be very popular in Maui. Dr. Nishigaya said the thought that what is being done by the individual doctors in the amount of time and effort they give in behalf of the Association should be taken into consideration.

ACTION:

It was moved and seconded that the dues for 1962 be increased an additional $5.00 over that recommended by the treasurer. The motion was passed with one dissenting vote.

O.A.S.I. FORMS

The letter from Dr. Morton E. Berk, which had been circulated, was discussed. Dr. Berk pointed out that an increased number of O.A.S.I. forms relating to disability will be submitted to the doctors with the change in the law and that in some states the Social Security people pay doctors for filling out the forms. He did not feel that the cost for this should be borne by the patient who is already threadbare financially nor did he think the form should be filled out gratis by the doctor, unless he has little information to report. He asked that the Council authorize each county medical society to write a letter stating that the doctors feel it is only fair that they be reimbursed for filling out these forms.

ACTION:

It was moved and seconded that the Council accept Dr. Berk's recommendation. The motion passed unanimously.

BUREAU OF MEDICAL ECONOMICS

Dr. Cushnie asked if any of the counties wanted information on the establishment of a BME. He said they could get it from Honolulu County and Mr. Kennedy said he would go to the other islands any time they wanted him. He said that whether this should be gone into is entirely up to the county societies.

ANNUAL MEETING DATE

It was noted that in 1962 when the annual meeting will be held on Maui, Easter is on April 22 and Mother's Day on May 13.

ACTION:

It was moved and seconded and unanimously passed that the 106th Annual Meeting be held on Maui May 3, 4, 5, and 6, 1962.

RECOMMENDATION OF THE VENEREAL DISEASE COMMITTEE

The Advisory Committee to the Bureau of Venereal Disease recommended that the Department of Health accept the Federal Government's offer to send out a trained venereal disease investigator who will try to determine why Hawaii's rate of increase in infectious syphilis is so low. The government had planned to keep the investigator in Hawaii for a full year but the committee's recommendation was that he not be sent out for a set period of time.

ACTION:

It was moved and seconded to accept the recommendation of the Advisory Committee to the Bureau of Venereal Disease. The motion passed unanimously.

WAIVER OF REGISTRATION FEE

A discussion on who should have his annual meeting registration dues waived noted that Dr. Harry L. Arnold's annual meeting expenses have traditionally been paid by the Association as a token of appreciation for the many hours he devoted to the JOURNAL. Also that the registration fees for local interns and residents, but not their breakfast, picnic. or other tickets have been waived. Dr. Allison thought that anyone who is invited to contribute to the convention should have his registration waived but that any doctor who is established in the community, and who could become an associate member if so desired, should not have his registration fee waived.

ACTION:

It was moved and seconded that Drs. Alvarez, Cline, and Arnold have their registration waived. The motion passed unanimously.

AWARDS COMMITTEE

The Awards Committee recommended that Dr. Joseph T. Nishimoto be selected to receive the Robins Award for outstanding community service. A list of his qualifications was noted.

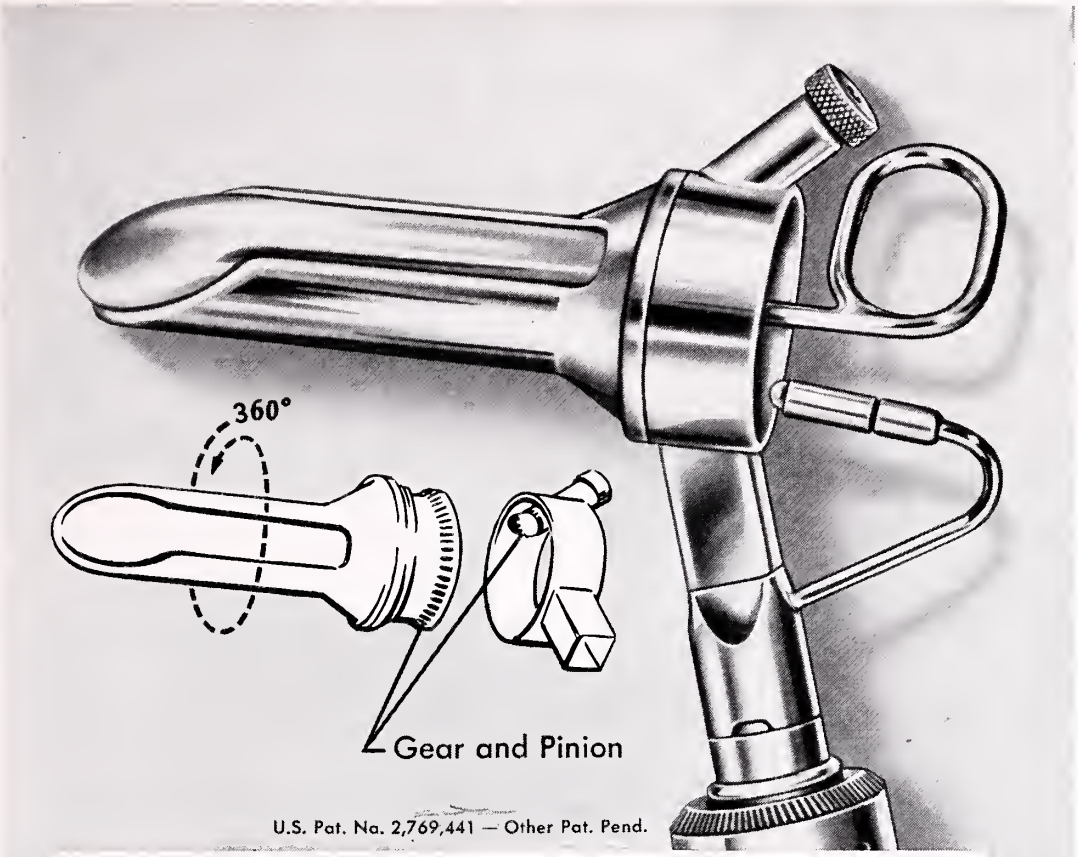
(Continued on page 490)

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HAWAII MEDICAL ASSOCIATION

(Continued from page 488)

ACTION:

It was moved and seconded that the recommendation of the Awards Committee be approved. The motion passed unanimously.

SCIENTIFIC PROGRAM COMMITTEE

The Scientific Program Committee asked for a ruling on inviting Dr. Donald Smith, who is still unlicensed, to participate in one of the panels. It was explained that the moderator, Dr. Richard Ho, wanted a neuro-surgeon on his panel and had been turned down by both Dr. Cloward and Dr. Bennett. Dr. Lowrey will be out of town.

ACTION:

It was moved and seconded that Dr. Smith be invited to participate on the panel and that the Scientific Program Committee be given the right to select the panel members of their choice. The motion passed unanimously.

LETTER FROM MAUI COUNTY

It was noted that correspondence had been received from Maui County raising a question of ethics of a Honolulu County member. It was pointed out that the Hawaii Medical Association has nothing to do with this problem and that each county has to discipline its own members. Dr. Burden said that Maui County didn't get a proper answer. He was advised that the only time the state Association can take action on an individual is when the individual feels he has been maligned by his county and appeals the case to the state.

The meeting adjourned at 11:25 P.M.

RODNEY T. WEST, M.D.
Secretary

BOOK REVIEWS

(Continued from page 461)

Cellular Aspects of Immunity

By G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B.Sc., 494 pp., $10.50, Little, Brown & Company, 1960.

It is unnecessary to recommend any of these excellent symposia to interested physicians. They all know about them already. This is up to the usual high standard.

Pseudomonas Aeruginosa Infections

By Claude E. Forkner, Jr., M.D., 104 pp., $5.25, Grune & Stratton, Inc., 1960.

All about pyocyaneus infections, with 465 references.

Diverticulitis

By Sara M. Jordan, M.D., and Russell S. Boles, Jr., M.D., 90 pp., $4.75, Grune & Stratton, Inc., 1960.

Lahey Clinic views, with a historical review and 122 references, into 1959.

The Structure and Dynamics of the Human Mind

By Edoardo Weiss, M.D., 472 pp., $8.75, Grune & Stratton, Inc., 1960.

This is for psychiatrists.

COUNTY SOCIETY REPORTS

(Continued from page 464)

no reference be made to the degree of perforation in the tympanic membrane and that the HMSA fee be $125.00.

ACTION:

It was moved, seconded and carried that the above recommendation be approved.

Tympanoplasty: The committee reaffirms its recommendation that this procedure carry a relative value unit of 80.0 and that the HMSA fee be $360.00.

ACTION:

It was moved, seconded and carried that the above recommendation be approved.

Dr. Freeman brought out that a great many businessmen in the community think that the HMSA $3.00 office call is the going rate. He suggested to the doctors that in order to convince them that it is not our average fee that when billing HMSA they put down their actual office visit charge and let HMSA put down what they will pay.

The meeting was adjourned at 10:50 P.M.

* * *

The February 7, 1961 meeting was held in Mabel Smyth Auditorium.

Dr. Alvin A. C. Paraz was welcomed in as a new active member.

(Continued on page 492)

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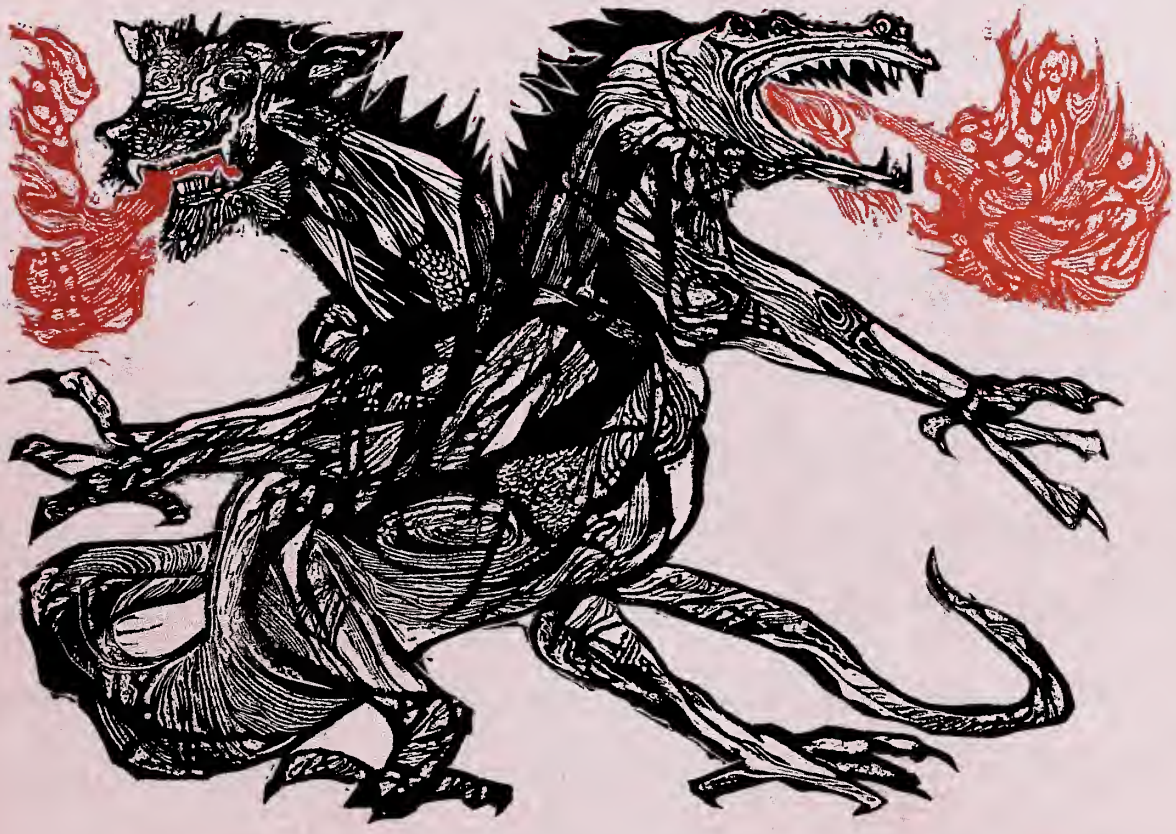
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COUNTY SOCIETY REPORTS

(Continued from page 490)

Dr. Batten presented a progress report of the new Medical Library. He called attention to the fact that the fund raising was by no means completed and mentioned that although 75% of the members have contributed to the building fund, this leaves 25% who have not contributed at all. He stated that the Library is happy to have any comments and recommendations from the membership regarding the building and its design. He also mentioned that the Library is looking for a qualified medical librarian.

Dr. F. J. Pinkerton gave a brief talk on the advantages of becoming a member of the Association of American Physicians and Surgeons.

Mr. Hugh Lytle was introduced to the membership as our new public relations counsellor.

Public Law 86-757: The Chair announced that the Medical Practice Committee has met on a matter concerning Castle & Cooke Terminals Ltd. selection of a panel of doctors to take care of seamen and stevedores injured on board ship. It was brought out that although they are within their legal rights to take such action, the committee feels very strongly that the selection of such a panel is not in the best interest of the patient and that its restrictive nature does not promote the best in good medical practice. The committee has made definite plans to meet with representatives of Castle & Cooke and Home Insurance Company on this matter.

Fee Adjustment Committee Recommendations: Dr. Freeman presented the committee's recommendations which were discussed and acted upon as follows:

Radiation Therapy of Cancer of Cervix and Endometrium: That HMSA pay full fees for procedure #4642 Local excision of lesion of cervix (Cauterization or conization) in hospital with conization and D & C ($83.00) followed by two procedures at full fees for procedure #4671. Insertion of radioactive substance in cervix uterus or both, with or without biopsy or dilatation and curettage ($78.00). The three procedures referred to are each an integral part of the complete management of carcinoma of the cervix by this method and full fee should be paid for each instead of being handled as in the usual manner for multiple procedures.

Action: It was moved by Dr. West that the above recommendation be approved. The motion was seconded and was carried.

Gastric Resection and Vagectomy: That the following procedures with the relative values be adopted and information be forwarded to HMSA after final action by the membership:

		RV
3115	Subtotal (or partial) gastrectomy with or without vagotomy	70.0 (no change)
3131	Pyloroplasty	50.0 (no change)
3135	Gastrojejunostomy	50.0 (no change)
3117	Pyloroplasty with vagotomy	60.0 (new listing)
3136	Gastrojejunostomy with vagotomy	60.0 (reduced from 70)

Action: It was moved, seconded and passed that the above recommendation be approved.

Constitution and Bylaws: The Chair announced that if there were no objections, tonight's presentation of the Bylaws would be considered as a first reading, and that a thorough discussion by the membership and action will be taken at the next membership meeting. No objections were raised.

Foundation Plan: Dr. Berk outlined once again the objectives of the Foundation Plan and in general enlightened the membership on areas which they did not understand. Mr. Kennedy reviewed an organizational chart of the Foundation Plan. He stated that the Medical Care Plans Committee hopes to get this plan in operation so that the Society can be ready to handle the federal as well as state employees medical insurance. He also stated that the Board of Governors has authorized our president to appoint one or more representatives from the Society to attend a workshop on the Foundation Plan to be held in California, March 18 and 19, and also if the membership so desires it, Mr. Boyd Thompson who has been very instrumental in setting up the Foundation in Stockton would be willing to come down here to talk to the membership at our invitation. In conclusion, Mr. Kennedy asked the membership if they would like to vote their approval of this plan tonight.

Following a lengthy discussion by the membership it was the consensus of opinion that final action on the approval of the Foundation Plan be deferred pending further study by the Medical Care Plans Committee.

Action: It was moved by Dr. Batten that the Medical Care Plans Committee proceed with swift study on the details of the Foundation Plan and present a progress report back to the membership at the next meeting. The motion was seconded and was carried.

It was moved by Dr. Palma that the Chairman and one member of the Medical Care Plans Committee attend the workshop in California and that the Society invited Mr. Thompson to come down here for a meeting with the membership. The motion was seconded and was carried.

* * *

A special meeting was called to order at 7:40 P.M., February 28, 1961. Approximately 150 members were present.

President Hartwell announced that tonight's special meeting was for the purpose of discussing further the Honolulu Foundation for Medical Care and to hear Dr. Donald Harrington, president of the Foundation for Medical Care of San Joaquin County, speak of his experience with the Stockton Plan since its inception six years ago.

A thorough discussion was held with a question and answer period.

* * *

The Honolulu County Medical Society met on March 7, 1961, in the Mabel Smyth Auditorium. The meeting was called to order at 7:30 P.M. Approximately 130 members and guests were present. Drs. Arthur J. Okinaka, Clarence S. Sakai, and David A. Sinclair were welcome into the Society.

A short talk on the "Objectives of American Association of Physicians & Surgeons" was given by Dr. F. J. Pinkerton.

An interesting discussion on "The 23rd Amendment (Repeal of the Income Tax)" was presented by Mr. Willis Stone, National Chairman for the Committee for Economic Freedom. A brief question and answer period followed.

A resolution in memory of Dr. Barney N. Iwanaga was presented by Dr. C. M. Burgess.

WHEREAS, Barney Noboru Iwanaga, born in Honolulu, Hawaii, received his degree of Doctor of Medicine from the college of Medical Evangelists in 1934, and was licensed to practice medicine and surgery in the State of Hawaii in 1934; and

WHEREAS, Doctor Iwanaga was a member of the American College fo Chest Physicians, a member of the American Tru-

(Continued on page 494)

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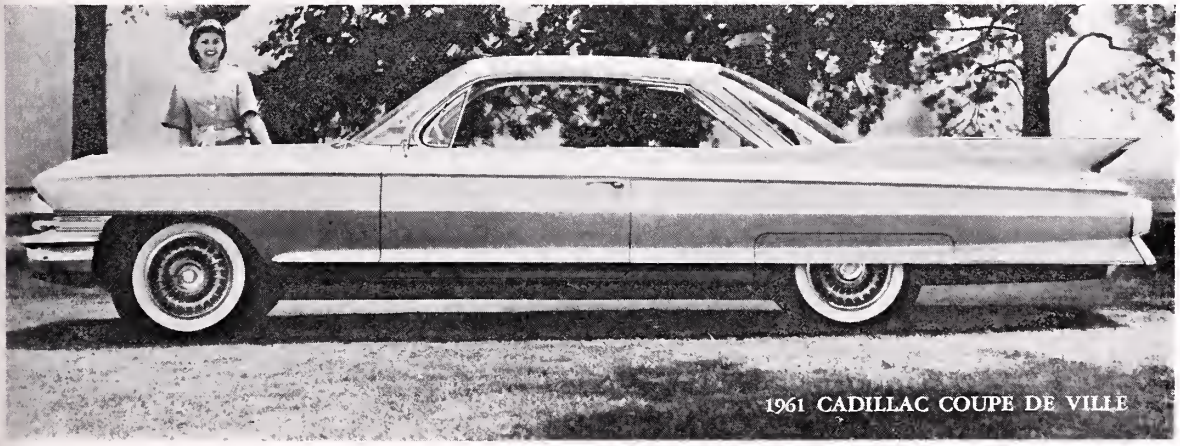


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(Continued from page 492)

deau Society, a member of the Honolulu County Medical Society, a member of the Hawaii Medical Association; and

WHEREAS, Doctor Iwanaga gave unstintingly of his time for community affairs especially in the field of sports, being State Boxing Commissioner, President of the Amateur Athletic Union and Chapter Physician to that organization, and furthermore active in the Boy Scout Troop 14 since 1918; and

WHEREAS, Doctor Iwanaga practiced medicine and surgery with superior skill and in the highest dignity and tradition of his profession; now, therefore,

Be it resolved, By the Honolulu County Medical Society that the Society mourns the passing of its member, Barney Noboru Iwanaga; and

Be it further resolved, By the Honolulu County Medical Society, that this resolution be spread upon the minutes of the Society and that copies be sent to his widow and to his son and daughter.

A motion to accept the above resolution was made, seconded and passed. A minute of standing silence was observed by the membership in memory of Dr. Iwanaga.

Castle & Cooke Panel of Doctors: Dr. Pinkerton reported that the Medical Practice Committee has met with our lawyer and representatives of Castle & Cooke and the Federal Commissioner on the matter of the selection of a panel doctors by Castle & Cooke to care for seamen and stevedores who are injured on board ship and have come up with the following recommendation as a possible course of action for the Society to take: The Medical Practice Committee recommends that "the Honolulu County Medical Society recommend to the panel of physicians that they request Castle & Cooke to abandon the panel and to remove their names from the panel, and that the Honolulu County Medical Society urges that no other member of this Society accept appointment to such panel." The committee feels that this action maintains unanimity of opinion and purpose instead of letting some organization divide the Medical Society.

It was brought out in the discussion that although this action of Castle & Cooke is legal and such a panel does not violate the AMA Code of Medical Ethics, it was felt however that it does violate the principle of free choice of physician.

Action: It was moved by Dr. L. Q. Pang that the recommendation of the Medical Practice Committee be accepted. The motion was seconded and was carried.

A suggestion that the membership be circulated with this information was approved.

Honolulu Foundation for Medical Care: Dr. Berk brought out that the membership as a whole has been well informed on the Foundation Plan, having heard Dr. Harrington speak on the subject and having been circularized with material and information about the Foundation Plan. He also brought out that the Society has a good chance of tying in with Stockton's Foundation Plan to qualify for Plan 4(4)(b) in the Federal Employees Medical Plan and that we are racing against time, since a decision has to be made by May 1st if the Society wishes to participate in the next contract negotiations.

Dr. Berk then moved that the Foundation Plan as has been described to the membership be put into action by the Society. The motion was seconded.

A lengthy discussion followed on the Foundation Plan. It was brought out that tonight's action by the membership will be just to approve the Foundation in principle; that no action will be taken on the Charter and Bylaws; and that the incorporation of the Foundation will be done by the Board of Governors. It was also brought out that once the Plan is approved, work can go ahead on the setting up of the minimum standards and fee schedule which will be approved by the participating physicians at a later date.

Following the discussion, Dr. Berk restated his motion to read "that the Society accept the idea of the Honolulu Foundation for Medical Care and that the incorporation of the Foundation be done by the Board of Governors." The motion to restate was seconded by Dr. Johnsen. Dr. Ando requested that Dr. Berk's motion be divided into two parts to be voted on separately. The first part of Dr. Berk's motion to adopt the Honolulu Foundation for Medical Care was voted on and was carried. The second part of Dr. Berk's motion to permit the Board of Governors to incorporate the Foundation for Medical Care was voted on and was carried.

R. D. MOORE, M.D.
Secretary

Kauai

The monthly meeting of the Kauai County Medical Society was called to order at 7:35 P.M. by Dr. Patrick Cockett, incoming President on January 3, 1961, at the Wilcox Memorial Hospital Library.

Mr. Morris Shinsato, Attorney, spoke on the various aspects of medical care in regard to County Pensioners and Welfare cases, also the responsibility of the individual counties in this regard. The question of a fee schedule was discussed. Dr. Cockett appointed a committee to meet with Mr. Shinsato for further recommendations: Dr. V. Boido, Chairman, with committee members Drs. Boyden and Brennecke.

It was moved and seconded that Dr. J. M. Kuhns be placed on Honorary Membership effective as of January 1, 1961. This was unanimously carried. A dinner honoring Dr. and Mrs. Kuhns by members and wives of the Kauai County Society will be held at a later date. The Secretary is to make arrangements.

The question of payment for stenographical and clerical work was brought up by the Secretary. Following a discussion, it was stated that no one was paid in the past out of Society funds and no one should be paid in the future.

The following committee appointments were made by the President:

1. H.M.S.A. Delegate: Dr. W. Boyden; Alternate Delegates: Drs. P. M. Cockett and K. K. Fujii
2. H.M.A. Delegate: Dr. B. Wade
3. Legislative Committee: Dr. K. K. Fujii
4. Cancer Society: Dr. V. Boido
5. Tuberculosis, Public Health and affiliated fields: Dr. P. Kim
6. Program Committee for County Society: Dr. M. Brennecke
7. Publicity and Public Relations: Dr. W. Boyden
8. Board of Censors: Chairman, Dr. W. Boyden; Members, Drs. S. Wallis and V. Boido
9. State Medical Licensure: Dr. P. M. Cockett
10. Medical Indigents Program, Pensioners and Welfare: Dr. V. Boido
11. Sponsor to Women's Auxiliary: Dr. P. M. Cockett

* * *

A special meeting was held at the Wilcox Hospital Library on February 6, 1961. It was called to order by Dr. Cockett, President, at 7:50 P.M. Guests were Dr. Edward L. Cushnie, President of the Hawaii Medical Association, and Dr. Henry K. Silver, visiting Professor of Pediatrics from the University of Denver.

A communication dated January 19, 1961 from J. K. Burgess, Jr., County Clerk, County of Kauai, concerning medical services to County pensioners was read. It was moved and seconded that the H.M.S.A. fee schedule be presented as our initial plan. Further studies in this regard will be carried on by Drs. Boido, Boyden and Brennecke.

Dr. Boyden, H.M.S.A. Delegate, presented a discussion of the January 13, 1961, meeting held in Honolulu. Again the question of over usage of the H.M.S.A. plan by certain doctors and plan members was brought up. The majority of the Society members were in favor of

individual contracts between component Societies and the H.M.S.A. Medical Committee.

Dr. Henry K. Silver gave a very interesting dissertation on "Newer Developments in Care and Disorders of the Newborn Infant."

* * *

The regular monthly meeting of the Kauai County Medical Society was called to order by Dr. Cockett at 7:35 P.M. on March 9, 1961. The meeting was held in the library of the G. N. Wilcox Memorial Hospital.

Dr. K. E. Rusch, Psychiatrist with the Division of Mental Hygiene, was guest speaker.

Dr. Boido presented the final report on fee schedules for Kauai County Pensioners.

The following is submitted:

> The H.M.S.A. fee schedule would be followed for surgical and obstetrical cases. House Calls would be $10.00. Initial office visit (medical) $5.00 and $3.00 for subsequent visits. All members present were in agreement with this.

Dr. Rusch gave a very interesting presentation on the present status of the usage of newer drugs in psychiatric care.

W. W. GOODHUE, M.D.
Secretary-Treasurer

* * *

The Kauai County Medical Society held a regular monthly meeting on April 4, 1961, at the Wilcox Hospital Library.

A letter of transfer of membership from the Honolulu County Medical Society to the Kauai County Medical Society concerning Dr. Walter Herter was received. The matter was referred to the Board of Censors.

A lettter relating to possible radio dramatization of health problems, sponsored by Lederle Co., was referred to Dr. Boido for further study.

Dr. Boido reported on the progress of his committee relating to Medical Care of the Kauai County Pensioners and dependents. At the moment Mr. Shinsato has transmitted the fee schedule as approved by the members to the Finance Committee of the Board of Supervisors.

PETER KIM, M.D.
Secretary Pro Tem

IN MEMORIAM

(Continued from page 460)

epidemic. Judging from this letter, the doctor seems to have had as much training as many of his professional contemporaries, whether or not he ever received his M.D. degree.

That his erudition in fields other than medicine was recognized is shown when he was asked to deliver a lecture on geology before the Royal Hawaiian Agricultural Society, meeting in Honolulu in August, 1851, for which the Society treasurer was authorized to pay him $30. In 1861 we find the doctor holding a meeting of some 150 natives of Hana to explain the advantages and benefits of sugar cultivation. During his 20 years on Maui he continued to carry on philological and sociological studies. He was also something of an inventor, designing nautical and aeronautical devices.

Dr. Rae spent the last year of his life on Staten Island, New York, as the guest of a former pupil, Sir Roderick Cameron. He died there on July 14, 1872, at the age of 76.

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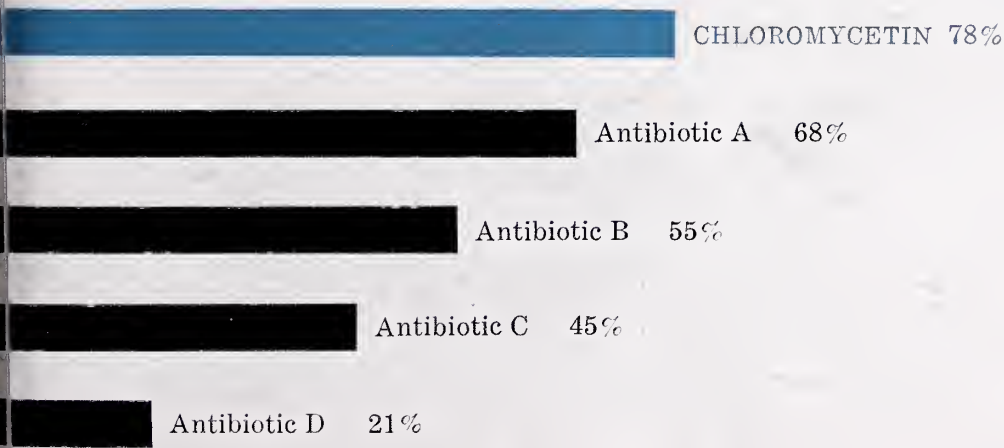
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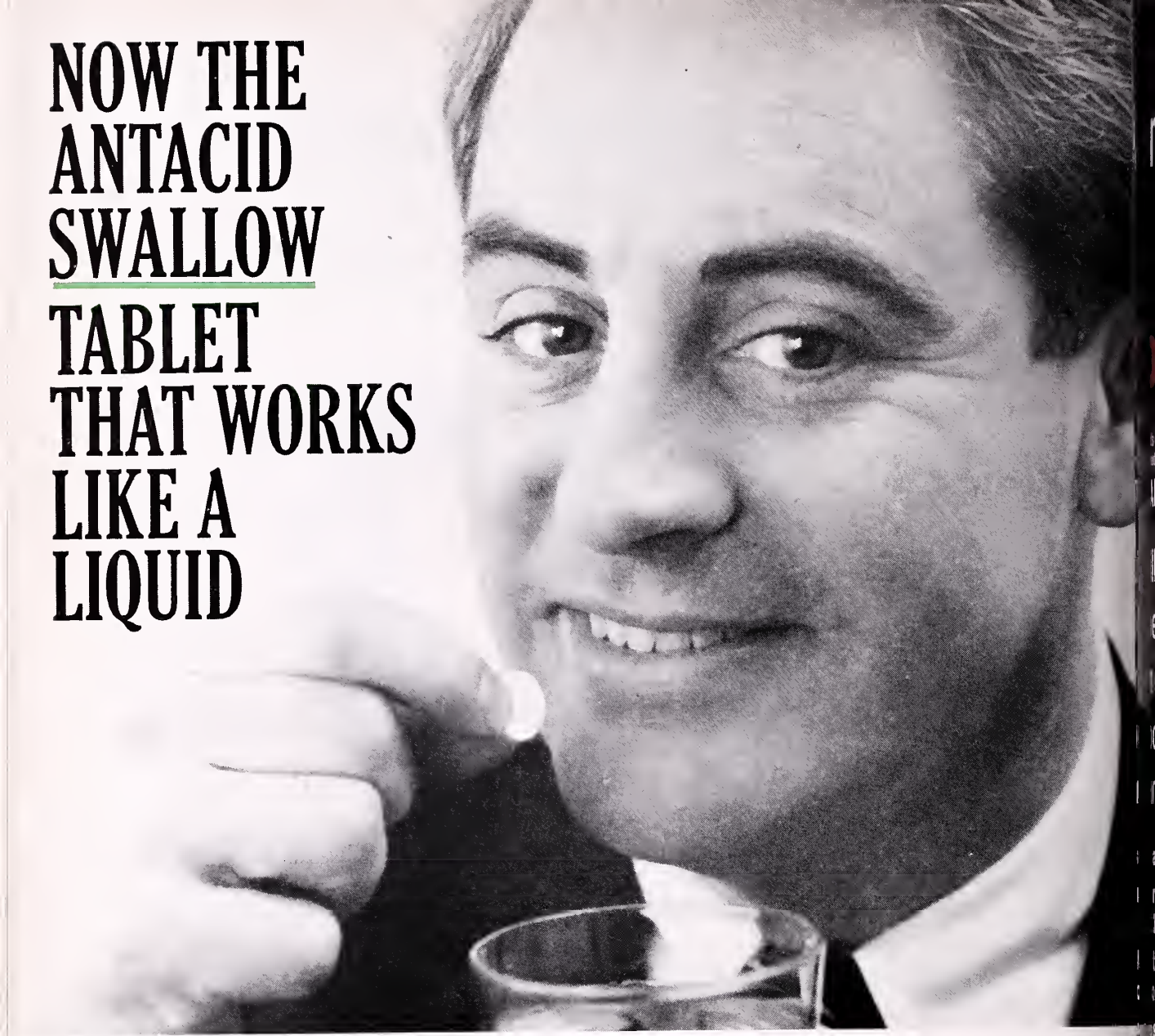
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"RIOPAN" is an entirely new chemical entity in which two agents with well established antacid properties — magnesium and aluminum hydroxides—are united in a single molecule by a patented process (U. S. Pat. 2,923,660). This chemical union makes possible a small, wafer-thin tablet that acts within seconds, providing therapeutic pH adjustment almost immediately.

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Dosage: 1 or 2 tablets **swallowed** with water as required, or 1 or 2 teaspoonfuls of suspension with water as required; preferably between meals and at bedtime.

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4 mg. acetylsalicylic acid,
0 mg. acetophenetidin, and
mg. caffeine.

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1. Blank, P., and Boas, H.: Improved analgesia for moderate pain, Ann. West. Med. & Surg. 6:376, 1952. 2. Bonica, J. J., et al.: The management of postpartum pain with dihydrohydroxycodeinone (Percodan): Evaluation with codeine and placebo, West. J. Surg. 65:84, 1957. 3. Cass, L. J., and Frederick, W. S.: A controlled study in pain relief, M. Times 84:1318, 1956. 4. Chasko, W. J.: Pain-free dental surgery: Postoperative extension of the pain-free state, J. District of Columbia Dent. Soc. 31:3, No. 5, 1956. 5. Cozen, L.: Office Orthopedics, ed. 2, Philadelphia, Lea & Febiger, 1953, pp. 120, 138, 145, 156, 234. 6. Nicolson, W. P., Jr., and Skandalakis, J. E.: Control of postoperative pain, J.M.A. Georgia 46:471, 1957. 7. Piper, C. E., and Nicklas, F. W.: Percodan for pain in industrial practice, Indust. Med. 23:510, 1954; abstracted, Clin. Med. 3:1008, 1956, Current M. Digest 22:135, No. 3, 1955.

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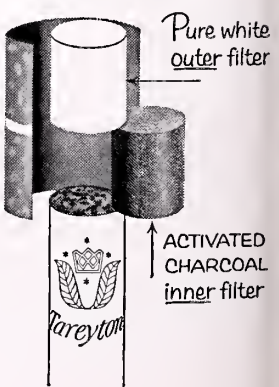
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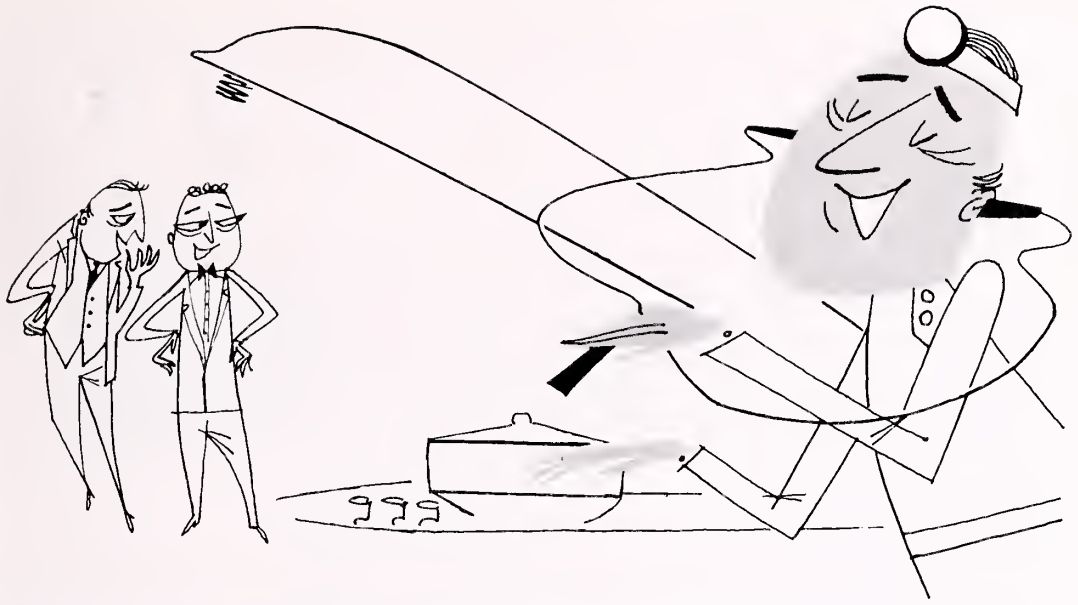
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1. Kareha, L. G., de Quevedo, N. G., Tighe, P., Kehrli, H. J., "Evaluation of Ilopan in Postoperative Abdominal Distention," Western J. Surg. Obs. & Gyn., 66:220, 1958.
2. Stone, M. L., Schlussel, S., Silberman, E., Mersheimer, W. L., "The Prophylaxis and Treatment of Postpartum and Postoperative Ileus with Pantothenyl Alcohol," Amer. J. Surgery, 97:191, 1959.

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*Silverman, M.: 48th Quarterly Meeting, Soc. Medical Friends of Wine, Jan. 13, 1960

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Solution	Dextrose	Milliequivalents										Calories	mOs.
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Isolyte® M Maintenance with 5% Dextrose For routine maintenance in adults and older children	50	40	35	—	—	—	40	20	—	—	15	180	400
Isolyte P Pediatric Maintenance For routine maintenance in infants and younger children	50	25	20	—	3	—	22	23	—	—	3	180	350
Isolyte E Extracellular Replacement in Water For replacement of intravascular, interstitial, transcellular losses other than gastric	—	140	10	5	3	—	103	—	47	8	—	10	320
Isolyte E Extracellular Replacement with 5% Dextrose For use as above	50	140	10	5	3	—	103	—	47	8	—	180	570
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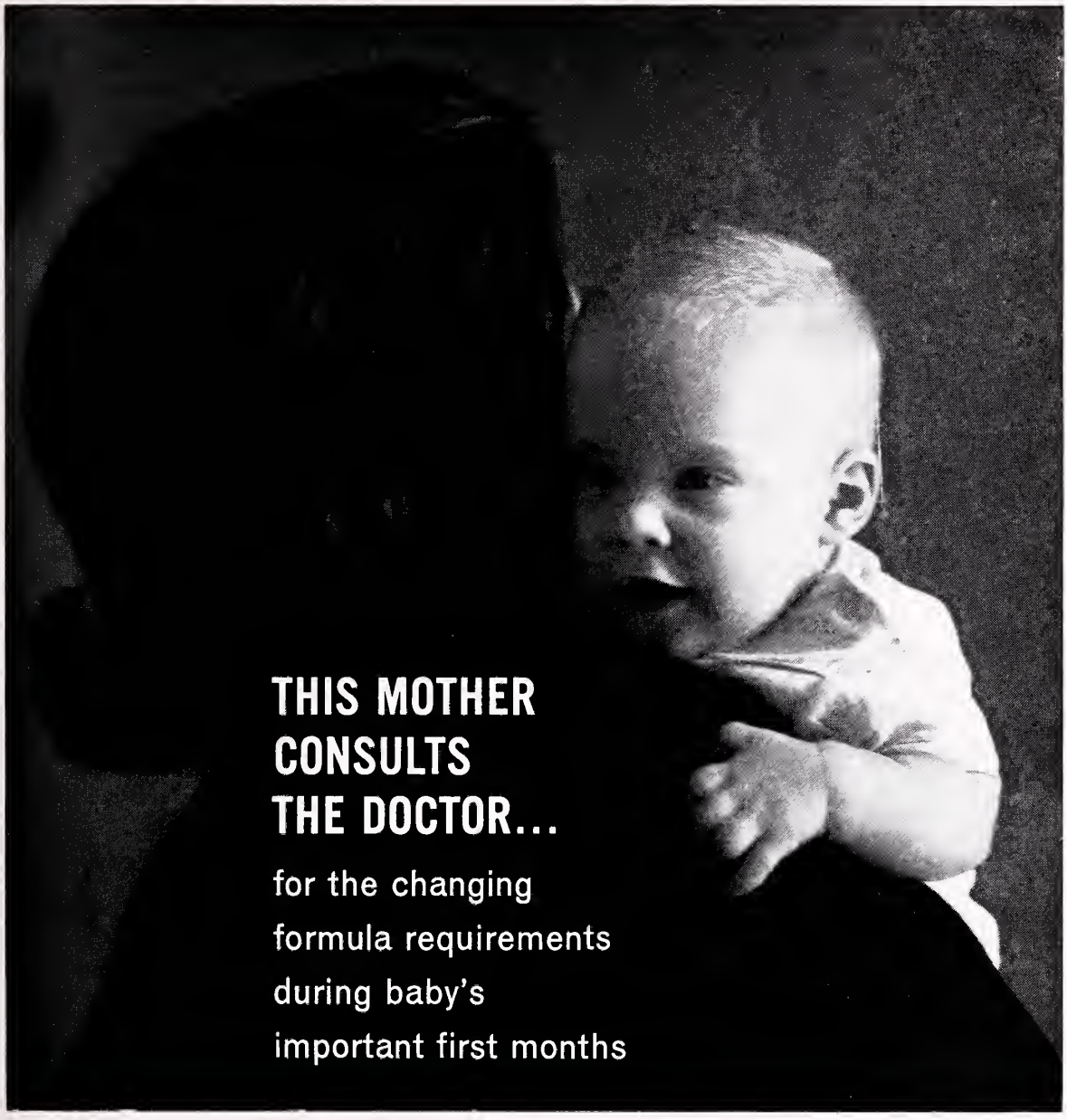
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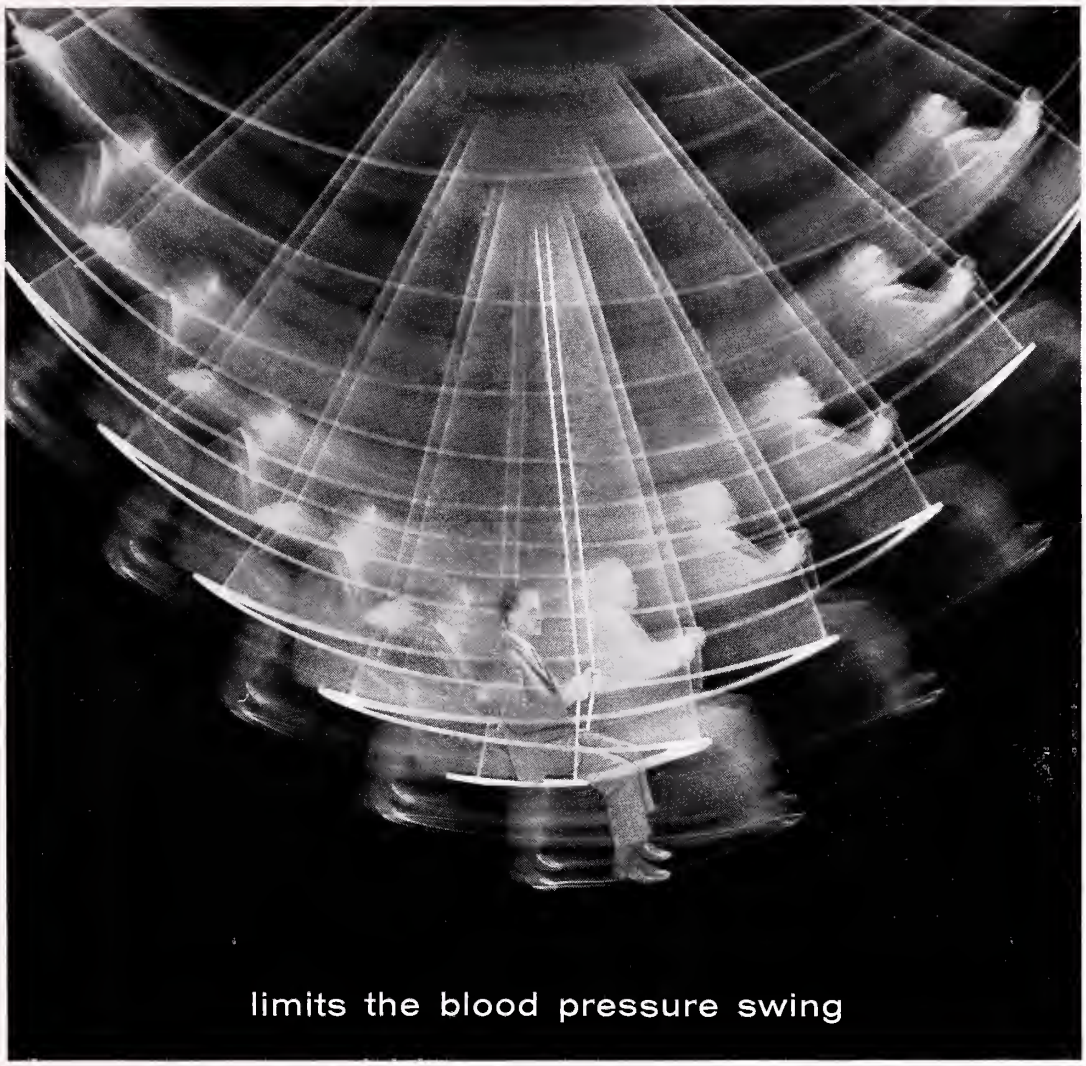
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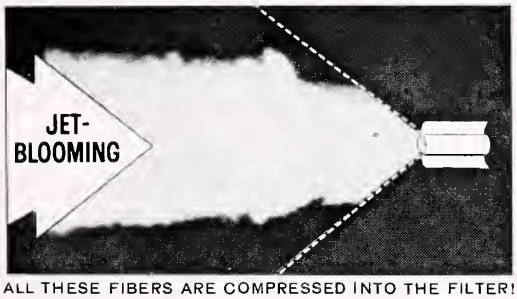
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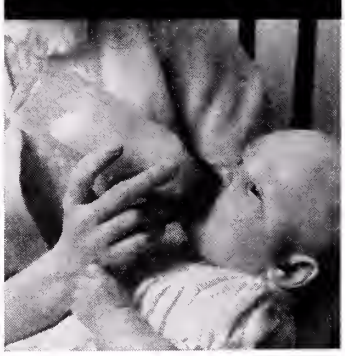
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a new study of basic standards in infant feeding



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Nitrogen retentions of infants fed breast milk or Similac were compared in the Metabolism Ward of the University Hospital at Iowa City — a homelike yet controlled environment. No solid foods were fed. Three-day balance studies were carried out on each infant approximately every 2 weeks for 6 months.

STANDARDS IN INFANT FEEDING

basis: BREAST MILK

The initial phase of investigation,[1,2] based on the primacy of breast milk as a reference standard in infant feeding,[3] was conducted to provide more detailed and sustained metabolic data than had previously been attempted. The authors derive from these data standard reference curves for nitrogen retention, as found in normal breast-fed infants.

comparison: SIMILAC®

The results with Similac showed progress in growth along normal curves. Nitrogen retentions occurred as with breast milk, in proportions relative to protein intake.[4] By the detailed metabolic criteria of the study, as by the clinical criteria of pediatric practice, Similac stands as a feeding closely comparable to breast milk.

SIMILAC SUPPLIES INFANT'S PROTEIN REQUIREMENT

"It is therefore concluded, as judged by these criteria, that the infant's requirement of protein from cow's milk is no greater than that supplied by ad libitum feeding of Formula S."[4]

References: 1. Fomon, S. J., and May, C. D.: Pediatrics *22*:101 (July) 1958. 2. Fomon, S. J.; Thomas, L. N., and May, C. D.: Pediatrics *22*:935 (Nov.) 1958. 3. May, C. D.: Pediatrics *23*:384 (Feb.) 1959. 4. Fomon, S. J., and May, C. D.: Pediatrics *22*:1134 (Dec.) 1958.

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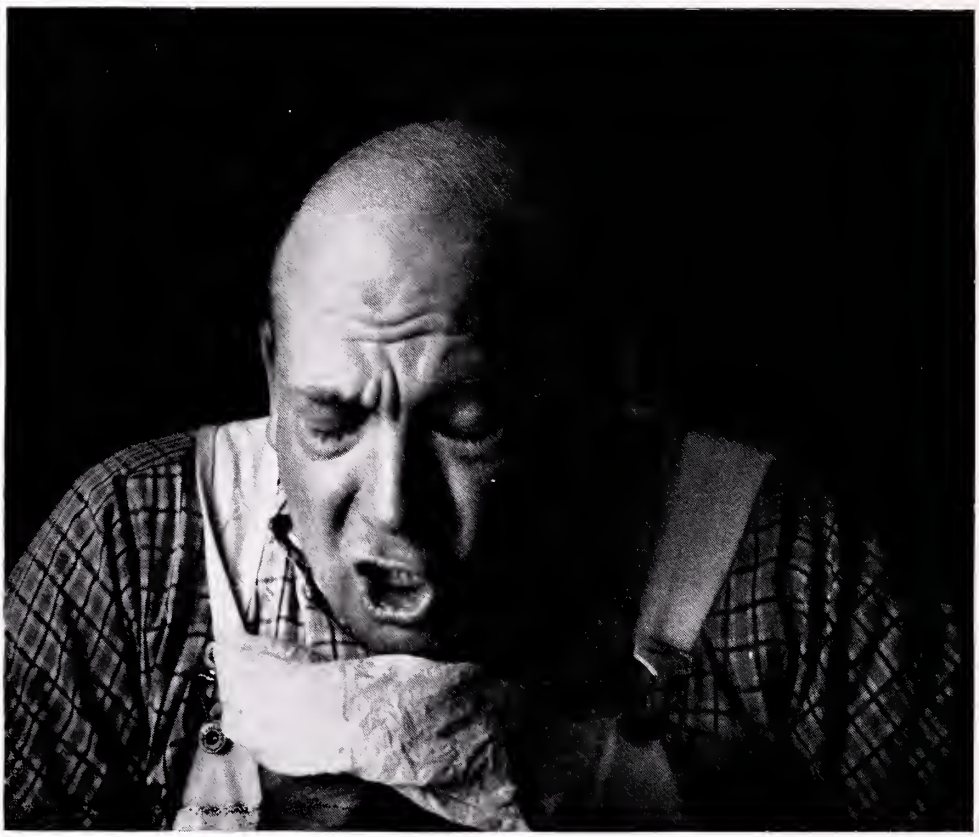
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1. Rogers, H.L.: Antihistamines: A Second Look, Postgrad. Med. *26*:85 (July) 1959.

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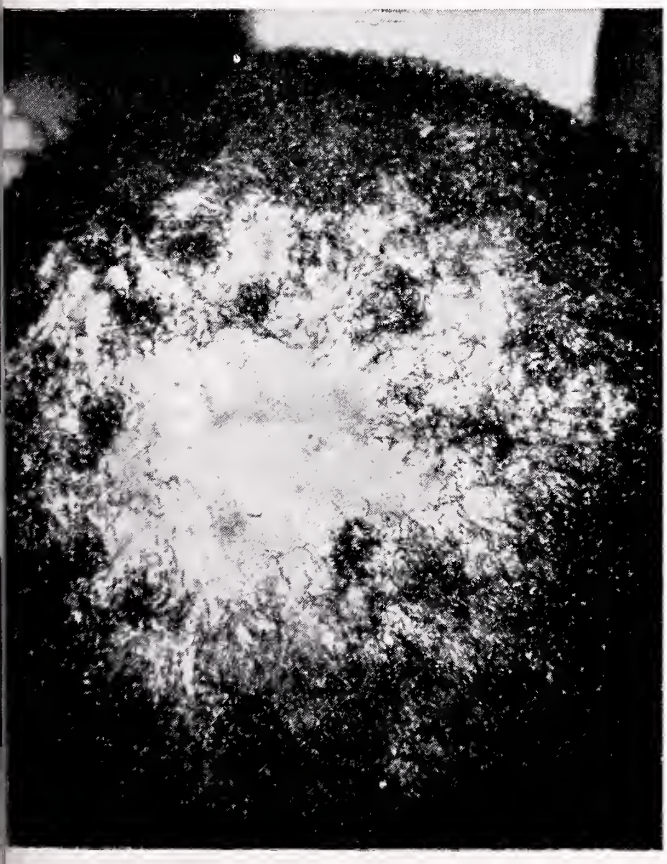
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Public Relations and Our Problems of Seeing Ourselves as Others See Us!

EDWARD F. CUSHNIE, M.D., Honolulu

Many, many years ago the Scotch poet, Robert Burns, wrote:

> Wad some pow'r the giftie gie us
> To see oursel's as ithers see us!

This was actually said two hundred years ago, and it is as true today as it was then. I will admit we have progressed from John Hunter's day, 1749, when surgery was delegated to the uneducated and to certain tradesmen, because of public opinion. We apparently still have the image of ourselves created in the era fifty years ago when we could do no wrong—in an era when medicine had men like Lister, Osler, Cushing, and a host of others. So while we kept the high esteemed image of ourselves, the public was creating its own image of the doctors and the profession, but I can assure you it is not the one we have of ourselves.



DR. CUSHNIE

Dr. Ravdin, speaking before the Pan Pacific Surgical Congress in 1954, said, "The spiritual side of medicine has not kept pace with the scientific aspects!" He added "The science of medicine has moved forward with tremendous rapidity. The art of medicine and the intangible something we call patient-physician relationship has come to a practical standstill!"

This brings us to the problem of public relations between the profession and the public. We have to give and take. For instance, the old picture of the family doctor is vanishing, if it hasn't vanished already.

People with an awareness recognize that scientific progress is the chief reason for the change. Likewise, they also recognize the relationship that once meant so much. The group that has this awareness comprises only one segment of the public served by the medical profession.

The other part of the public includes many on welfare because they are mentally and physically unfit for life and its environment. There are large and active elements in society who work devotedly to make America a Welfare State. Also, this does not mean that all the intelligent groups are necessarily in sympathy with the medical status quo. Some of the most active minds in the nation are arrayed in the fight for security from birth to death. They have met with good success in many issues. One before us now is the care of the aged, 65 plus, within the Social Security system. These groups and their representatives in Washington can only see it one way and that is LET THE GOVERNMENT PAY.

Now, to me, comes a very important phase, and that is how to get us to see ourselves as others see us. Even with the gamut of public relations procedures we still apparently are seen by many as a large union which negotiates with itself.

A profession which gives the idea—true or not—that it condones the loss of dignity in the individual by creating large charity wards, which advertise free clinics for those who have nothing, should see that idea is changed. And we advertise our benevolence because we do the work free.

Is the pregnant woman happy to leave her doctor and go to the hospital to get a free delivery? I wonder what the effect of this may be upon the

Delivered at the 105th annual meeting of the Hawaii Medical Association, May 5, 1961.

dignity of the husband. Does he think that this is what our medical society condones?

Dignity is defined in Webster's Dictionary as the elevation of character, intrinsic worth and the quality of being esteemed. Can anyone become esteemed by his fellow men by bragging about his staying in Charity Ward #20, or the wife to her neighbor that just had a baby in Ward #12?

On the one hand, we are brought up to pay for everything; a loaf of bread, a few dishes, and a fork. Everything we buy, for cash or credit, we at least try to pay for; but when it comes to medicine put a big sign up 'Charity and Free Clinics.' Nothing else has this type of advertising. You don't see the grocer with a sign 'Charity—Bread Given Away Here.'

Now, I don't believe anyone of us feels that it is all our fault. Remember the doctors are the only profession with this gigantic setup. Regardless of whether this is our doing or not, it's here now. That is how others see us, and I think its about time we started seeing ourselves as others do. We must change a few things to keep up with the present day. And I am sure that the dignity of the individual will reward the doctors a hundredfold. Public relations is a large phase but remember until we do give the individual some way to keep his dignity, we will never have his help—remember, everyone loves his doctor but does he love the profession?

To sum up this feeble thought, there is nothing against public relations we now use. However, there is an intangible factor which I feel is very important and that is that our thinking will have to change to present day thinking as people do not want paternalism, advertised charity wards, or free clinics, nor do they want a form of colonialism as we now have between some nations.

Look around you and you will see that the very people of nations we help are against us. They want another type of freedom, with what they call 'dignity of man.' Well, this I feel is the same as what the individual wants from the medical profession and all its ancillaries, the right to be able to pay.

During recessions, do the unemployed have to be paupers to get needed attention? Why should they? They are hard working families, laid off by no fault of their own.

If we do not want socialization of medicine then we better work with the insurance, the public, industry and the hospitals in a different way than we have.

I am afraid our benevolence is not the answer. The whole medical thinking of paternalism will have to change on this one point and help the individual get the right to somehow get medical attention not our way but theirs.

Each time one criticises, one should give examples of correction.

1) Much already has been done in Service Plans like the HMSA, Blue Shield, and the Honolulu Foundation for Medical Care. These resulted from co-operative thinking.
2) Whether we like it or not, we must work with labor, industry, and insurance in a more positive way.
3) We should be the prime mover in attempting to get comprehensive medical care for the people. Sit down with them and negotiate plans, not just fees.
4) Remember the fear of illness and how we can get taken care of is a real and profound one—a basic one.

I know we all realize the situation but thought I would emphasize it a bit. After all we have a great and esteemed profession.

Whether we agree on methods isn't important. What is important is that we recognize the existence of the problem.

I would at this time like to thank all of you for having given me the honor of being your President for the past year, and also thank all of you for giving your time and effort to the Society.

1441 Kapiolani Blvd.

If you would avoid needless diagnostic errors, don't stop—but do look, and listen!

The Vanishing Art of Diagnosis with the Eyes and Ears

WALTER C. ALVAREZ, M.D., Chicago

WHY AM I talking on this subject of diagnosing with the eyes and ears? Because, as a medical consultant, I am constantly seeing patients whose experience shows me how important it is today for us to go back, to some extent, to rely on a good history with some good observing and some good thinking.



DR. ALVAREZ

Some of you may not feel that the problem is so important, but I can perhaps emphasize my point by telling you what happened a while ago to a distinguished physician, a friend of mine who, while in the East, decided he would have a "complete checkup" in a great institution of learning. In order that he be treated as a layman, he went in under an assumed name. He told me that he had $425 worth of laboratory tests and x-ray studies, but no history was taken and no physical examination was made! The eminent physician who finally saw him hardly looked at him and spent only ten minutes with him for a summing up. During this time, all he did was to thumb through the reports. Then he said, "There is nothing the matter with you," and told the man where he could pay his bill on the way out. I am sorry to say that hundreds of patients tell me that that is the sort of experience they now get in many clinics and university hospitals.

Text of extemporaneous address given before the 105th annual meeting of the Hawaii Medical Association, May 4, 1961.

Take a History!

Naturally, this type of practice leads to the making of terrible diagnostic mistakes. As you well know, there is no laboratory test that will tell you that the woman sitting on the other side of your desk is dying of a broken heart or is going insane.

Also, today, one of the commonest mistakes is made even by teachers of medicine who immediately assume that if a gallstone has turned up during the x-ray examination of the patient, this finding explains all her troubles. In two of the last cases I saw in which this mistake had been made, the elderly patient's syndrome was due to a serious stroke which had taken away much of the woman's memory, and most of her feelings of physical and mental comfort. Naturally, the cholecystectomy which was quickly performed did not do her any good, because her gallstone had been entirely silent. In my 25 years of dealing with keen, well-trained graduate students, I was much impressed by the fact that, day after day, when the x-ray department reported the scar of a duodenal ulcer, or a gallstone, or a diaphragmatic hernia, my assistant felt that the diagnosis had been made, and hence there was nothing more that he needed to do, except perhaps to order an operation.

When, in these cases, I sat down to take a care-

ful history, I could see from my assistant's attitude that he thought I was weak in the head, and was only wasting my time and his. Why should I be talking to a patient "whose diagnosis had been finished?" Actually, in hundreds of cases, I was able to show my assistant that the patient's symptoms were not those of the abnormality he had found, but perhaps were those produced by great unhappiness over an alcoholic husband or a mentally defective child, or were produced by a severe migraine or a beginning psychosis. What was sad was that, with my assistant's training such as it was, in the end I could not convince him that the gallstone he had found was silent, and that there was some significance to the fact that, all of a sudden, one day, with a terrible dizzy spell, the patient had lost part of her memory and all of her interest in her home, her children and her husband.

"There is Nothing the Matter with You"

One of my greatest objections to the practice of my young assistants was their tendency to say to a patient, after he had been put through the diagnostic mill and had come out with negative findings, "There is nothing the matter with you. You are dismissed." For 25 years I tried, without much success, to get my young colleagues to see that when they said, "There is nothing the matter with you," their work was not ended; it should be just beginning. I would say, "Look, here is a woman who has travelled one thousand miles because of a terrible headache or a distressing stomachache or miserable spells of nausea and dizziness. Why don't you sit down at least for ten minutes to try to find out why she has these symptoms?"

I will never forget the woman who had been dismissed with the statement, "There is nothing the matter with you." I saw her because, tearfully, she maintained that she just could not go home without any hope for the relief of her terrible attacks of nausea and headache. On sitting down with her for a chat, I found that what she had was a very severe form of migraine which had come back to her in her early forties. Obviously, there had to be some cause for the return of her migraine, and I soon found that her trouble was that she had fallen in love with an alcoholic man seven years her junior. She very much wanted to marry him, but she knew that she would end up supporting him, and she was already supporting her aged mother. It was her inability to make the all-important decision which had thrown her into one spell of migraine after another. As she said to me, she could not face going home without help because if she went on having two terrible attacks of migraine a week she would soon lose her job as a buyer in a store. When I succeeded in convincing her that she must not marry the man, and when she slept well again, she was well. I could go on for a few hours telling stories of this type, all showing that with the sort of training that many of our young physicians now get, they see no need for using their eyes and ears, and hence they fail to help hundreds of their patients.

Also, in many cases, they make serious mistakes in diagnosis. Often, the diagnosis is so easy that any good intern could make it if he just used his eyes and ears and did a bit of thinking. I am particularly distressed when I see mistakes in diagnosis which were made by men of considerable eminence and ability. Often such a man is deceived by a brief history taken by his nurse or assistant.

Is it Really Pain?

For instance, a hundred times I found on the history written for me by an assistant, "The patient has abdominal *pain*." When I asked the patient, "Is it real pain," she said, "Oh, no, it is butterflies," or "a burning, perhaps, in my skin," or "it is a constant misery," or "something in there that I would like to turn over," or "it feels like a little gas," or "it feels like a little cramp in my muscle." This answer changed the whole aspect of the problem because pain commonly goes with organic disease whereas butterflies and burnings and widespread miseries are usually arising in the brain.

Where is the Pain?

Also, a hundred times I have seen a physician make a serious diagnostic mistake because he accepted the statement recorded by his nurse that the patient had pain "in his *stomach*." Actually, when I asked the invalid to show me with his hand just where it was, I found it was in his suprapubic region or perhaps even in his rectum. I remember a man who lost his life because a good doctor accepted the diagnosis of "stomach" pain, and then accepted the diagnosis of duodenal ulcer made by a roentgenologist. I asked the man of 55, "When did you have hunger pain," and he said, "Oh, that was about 25 years ago." Obviously, he had only a scar of an old ulcer. Then I asked him, "Show me exactly where your pain is," and he pointed to his rectum. What he had was a cancer of his rectum that did not look operable. Six months before, when his doctor started to treat him with a Sippy diet, the tumor could probably have been removed.

Many a time my assistant has been satisfied that a "pain in the stomach" was due to a gallstone. If he had asked the woman to point to where her pain was, he would have found it was in her pelvis or over her left hip. Such pain could not possibly be due to gallstones. Hundreds of times I have

had to point out to my assistant what I have already said, which is that the laboratory report was correct enough, but it could not explain the patient's syndrome.

Is the Laboratory Report Wrong?

In other cases, the laboratory report was not quite correct; and here is a very peculiar quirk of our medical thinking. I practically never find a new assistant who will question a laboratory report. To him, it is like Holy Writ. It never occurs to him that a girl could make a mistake just as he and I could. Also, it never occurs to him that, in the process of copying a laboratory report, it might get altered.

To show what I mean: one day, a slightly overweight, healthy-looking, ruddy, active and wide-awake man of 40 came in and told me that he had an inoperable carcinoma scattered all over him, but he wondered if perhaps still something could be done. I asked, "How do you know you have cancer all over you?" "Because my doctor found a red blood sedimentation rate of 115 in an hour." I repeated the test and found it was 3 mm. And this is so strange. As I said, I rarely find an assistant who will ask for the repeating of a laboratory test, even when the report is much out of line with other findings. One marvels at the fact that the able internist who saw my patient did not think to have that report of the sedimentation rate repeated when there was every reason for believing it was wrong.

I then called the doctor long distance and asked him to look up the original report in his laboratory. Soon he phoned to say his secretary had copied the *blood sugar* report of 115 mg. in the space on the history sheet reserved for the red blood sedimentation rate! I would not mention this happening if I had not seen this sort of thing many a time. I remember the young woman from a diabetic family who was scared into a miserable nervous state when a girl in a doctor's office, in copying her blood sugar reading, reversed figures and turned 117 into 171 mg. Again, it was curious that the doctor did not note that there was no sugar in her urine, and hence he had better check the blood sugar reading. He simply said, "You will be a diabetic some day." At the time, this doctor, an able and friendly man, was President of the A.M.A. I mention this just to show that the best of us can slip at times.

Finding the Expected May Fool You

One must be particularly careful when one finds what one expects. Years ago, the great Dr. Ludwig Hektoen always used to say so wisely, "Look out when you find what you expected to find—then you are in danger." To show what I mean, one day there came into my office a man who, as my desk girl said, was obviously a "screwball." He had waxed moustaches, an artist's big bow tie, a colored vest, a cane, and spats. He complained that he had a pulse of 130 per minute, and actually, he did have it.

My assistant, who saw him first and worked up his case, diagnosed hyperthyroidism, and when the report came back from the lab that his basal metabolic rate was plus 35, the young doctor was absolutely certain that the diagnosis had been made. Later, he could barely conceal his annoyance with me when I said, "But wait a minute. The man has no goiter, no exophthalmos, no unusual winking, and no tremor. His hand is decidedly cool, which practically rules out hyperthyroidism. He has no extra perspiration, as you can see by looking at his armpits, and he tells us he has no insomnia and no diarrhea. Also, notice that he sits quietly in his chair." Because my assistant had been so certain that the laboratory girl had made the diagnosis, he had not bothered to notice that the man was decidedly an eccentric, and he did not know that in rare cases such men can have a rapid pulse which can run sometimes for months.

I insisted that the measurement of the basal metabolic rate be repeated, and this very much annoyed my assistant. He could see no sense to it. As I told you, no assistant is very likely to repeat a test because he is always sure it must be correct. I turned to the patient and said, "When you had that mask over your face, did you get an attack of the 'let-me-outs'?" He said, "Did I! I was sure I was strangling to death." Incidentally, the laboratory technician had reported that the test had been very unsatisfactory, but my assistant had not bothered to notice that. On the second test, the man was quieter and less fearful, and the report was plus 12 per cent. To my assistant's disgust, I said, "Send him back for two more tests." The next was a minus 3, and the next was minus 12. In the meantime, I had asked the wife to take the man's pulse when he woke in the morning, and she found it to be 62 per minute. Also, as the man became accustomed to me, and as I reassured him, his pulse dropped down below 100. We could not find anything wrong with him except his tremendously over-active autonomic nerves.

Be Observant! Don't Ignore Details!

The easy acceptance of laboratory diagnoses discourages observation. I used to marvel at what an able assistant would not see or notice when he was sure that the diagnosis had already been made for him. To illustrate: one day I came into the office to check up on the case of a man whose problem had been studied for days by my assistant. A man

of 60, he had sparse hair which should have been gray, but it was grass green! My assistant had not noticed this and was surprised when I pointed it out to him! Why did he have green hair? Because his work was sand-papering bronze tubing. Actually, this had nothing to do with his illness, but I thought it should have been noted.

One day, several assistants had failed to make a diagnosis in the case of a kindly, stout old man whose only complaint was that he was so horribly tired he could not even go fishing. The diagnosis was obvious at a glance. It was a very hot July day and the man had on heavy winter galoshes. I asked him what he was doing with those and he said, "Oh, Doctor, I am so cold." He, of course, had myxedema.

One of my most interesting cases was referred to me by the president of one of our great national corporations. This president wrote me that the man, his export manager, for a few months had been unable to do his work. The president had referred him to four able internists in succession, and all had reported that, by every test, he was normal. When he arrived, one glance showed what the diagnosis probably was. He was so slowed-up and dull that no one would have hired him to trim a lawn. Obviously, something had hit his brain hard. I asked his wife and she said that the great change had come in a moment, one day when he fell out of his chair. After that, he could not even answer his mail. It was not hard to diagnose a little stroke. When I telegraphed the president that the man could be retired for medical reasons and that a letter would follow, he soon phoned asking, "What did you find, what did you find?" I said, "Gravy on his vest," and the president said, "Thank God you saw it!"

The only sad thing about this case is that four able internists had not seen the gravy. They probably had not seen the man dressed, but only when draped for an examination. But still, they certainly should have seen his expressionless face and noted his slow uncertain answers to questions. They should have seen that he did not look at all like a high-powered executive.

Remember Psychoses!

A similar case was that of the head of a big branch of an insurance company who was referred to me by his chief in New York. The chief said that something had gone wrong with him so that he was letting his office run down. His men were leaving him. As in the previously-mentioned case, the chief said that he had had the man examined by several internists who reported that, by all tests, the man was perfectly normal. There was "nothing the matter with him."

When I saw him, he was so very "pally" and talkative that I got a hunch, and going out into the waiting-room, I got his wife and asked her if he was always that excitable and "lit-up." She said, "Oh, no, he is now in one of his excited periods. Soon, he will be terribly depressed and will sit in a darkened room wringing his hands and crying." He was as typical a manic-depressive as one could find in a mental hospital. Very strange is the fact that when I told his family doctor and my assistants what was wrong, they looked at me as if it was I who had lost my mind. But why shouldn't they fail to recognize a manic man when even today, in many of our medical schools, the students are not shown insane persons, and are not warned that the commonest disease in this country is a mild psychosis. As a psychiatrist said recently, today in America, the commonest disease to be missed in doctors' offices is a depression. A number of times a doctor has brought into my office his wife with a bad depression written all over her face. He had never suspected what was wrong. Some of these men had had the wife's appendix removed!

I recently saw a woman of 65 who kept walking up and down my office in the agony of an "agitated depression." She could not sit down. Her two sons who came with her said that she walked about the house all night "in a terrible state of restlessness." I would not blame you at all if you would not believe this, but the woman's sons told me that, six months before, when they took their mother to a great institution of medical learning, she got a cholecystectomy; and four months later, when they took her back, she got a perineal repair! If ever a woman needed sedation in a mental hospital, she did.

Emotions May Cause Disease

Recently, I saw an interesting "asthmatic" who had been from one allergist to another without getting help. Why? Because she did not have asthma. If the allergists had looked at *her* and not at the reports of *skin tests,* they might have seen that what she had was only a hysterical imitation of asthma. Then, if they had asked her what was wrong in her life, they would have learned that her attacks of hysteria came when her "devil" of a mother insisted that, on her way home from her day's work as a secretary, she stop and get her mother's dinner before she went on home to get her husband's dinner. The poor girl could not make up her mind what to do. When I helped her to stand up against her mother, and to go home to her husband, she got much better.

One of my most interesting cases was that of a lad who was brought down from Canada by his mother. He had a pain "in his stomach." When

my assistant found no cause, he dismissed the boy, but the mother refused to go home, and so I was called in. I am sure that if I had the boy here and asked him to walk up and down before you, you would all say immediately, "A gawky Simple Simon who is slightly spastic, with his fingers sticking out at all angles." Curiously, my assistant had not made any note of this, and it had not caused him to do any thinking. As one of England's greatest diagnosticians once said, "None of us will ever be worth a hoot as a diagnostician unless, often, he will think of what his patient might have."

I immediately thought, as I am sure most of you would think, "This boy could not possibly succeed as a barber." He was too clumsy and awkward. But, on his history, it said that he was a barber. When I asked him how he liked barbering, the tears came to his eyes, and he became excited and said he just could not stand it. He said his father, who was a laborer in the pulp mill, had wanted his son to be "a gentleman," and so he had insisted that he go to barber school. When he graduated, the father's barber gave him a chair in his shop. But, as the boy said, when he tried to shave a man, he always cut him, and when he tried to cut his hair, the man said it was awful, and "became sore as a goat." Hence, in a few days, the boy told his father he was not going back to the barber shop. The father said he had spent the money, and the boy had to be a barber—or else. Then the boy got a terrible stomachache, so bad that he could not work. Obviously, the only thing that stood between him and a very angry father was the pain. When I telephoned the father and talked him into letting the boy work in the pulp mill, that was the end of the stomachache. Often, it is just as simple as that; all one has to do is to observe a bit, and then to think a bit and perhaps ask a question or two.

One thing that I would urge on you, and that is to spend at least one-half an hour taking a history. Many a time, through the years, I have had to talk to a patient for half an hour each day for a week or ten days before the cat came out of the bag and the diagnosis became obvious. One of the worst cases of this type that I now remember was that of a painfully thin, but keen little business woman who complained of severe abdominal pain. For days, she told her story so poorly that all I could guess was that she had some type of a neurosis. But one cannot treat a neurosis unless one knows what the cause is. In this case, on the tenth day, the woman happened to mention the fact that her spells of abdominal pain were associated with severe headache and nausea, and that they began with a pain in her left eye. With that, at last it was obvious that what she had was migraine. During the next few weeks, I stopped each attack of migraine with an injection of Gynergen and, as a result, the woman rapidly gained back her weight and soon was back at work.

The point I would now make is that no amount of laboratory work could ever have made a diagnosis like that; and yet, today, I find a greater and greater tendency on the part of both physicians and laymen to trust to a "complete examination" for their diagnosis. Today, thousands of people are convinced that if they can only get a thorough enough examination, they can be cured. Actually, as you know, this is not true.

I hate, in all this, to be critical of some of the things we doctors do or fail to do, but those of us —you and I who teach—would be derelict in our duty if we did not keep calling attention to ways in which our medical teaching could be improved. One thing that now eases my conscience is that every one of the mistakes of others which I now decry, I committed myself in my untutored and ignorant youth. Also, it comforts me that around 1925 I heard Dr. Herbert Moffitt, the famed Professor of Medicine at the University of California, protesting against "the tendency of doctors to try to get their diagnosis ready-made by a laboratory girl."

My revered Chief, Dr. W. J. Mayo, used to say, "We do not fully appreciate the value of our five senses in estimating the condition of the patient." Two or three days after an operation, Dr. Will could walk into a room, and often tell at a glance whether the patient was "going West." He did not have to ask a question or look at the chart. Also, he said, "I have been surprised to note the readiness with which high-grade young men, graduates from medical institutions which are models for our time, yield to the temptation to get a machine-made diagnosis."

Summary

With laboratory and x-ray reports one cannot diagnose many a functional disease. Even when a gallstone is found, it may not be the cause of the symptoms. In thousands of cases, the diagnosis can be made only by an observant and thoughtful physician who will take a long and careful and illuminating history. The man who tries to diagnose without the help of a history and shrewd observation is bound to make hundreds of mistakes.

700 No. Michigan Blvd.

Anyone who practices obstetrics should read and re-read this instructive article.

Resuscitation of the Newborn

JOHN R. STEPHENSON, M.D.,* and JOHN F. HANLEY, M.D.,† Honolulu

THE PROBLEMS confronting a physician who is faced with an apneic newborn infant are extremely complex, and upon his wise management of them depends the future and well being of the infant. That these problems are also extremely perplexing is likewise understandable, for there are great gaps in our knowledge and understanding of newborn respiratory functions and their derangements. Nevertheless, certain principles of resuscitation seem well enough grounded in fact that we may outline a program which will be sufficient for most cases. This program is twofold; the provision of *assistance* to the infant in establishing normal respirations, and the strict *avoidance* of anything which might hinder this normal physiologic function.



DR. STEPHENSON

If our current concepts of the mechanism initiating spontaneous respirations are correct, the normal infant with an unimpaired nervous system will be sufficiently stimulated at birth by exposure of its body to air to institute normal, rhythmical, efficient respirations almost immediately. If on the other hand, the central nervous system is impaired in any way; is injured prenatally, or during the process of labor or birth; or is unduly depressed by anesthetic or other therapeutic agents, this stimulation by contact with air may be insufficient to trigger effective respirations. Under these circumstances the chemoreceptors sensitive to anoxic states may be stimulated to function as they do in a more mature person and thus in turn stimulate increased cardiac output and respiratory effort. However, the injury or depression may be so profound that this too is ineffective and further stimulation from exogenous sources may be required. Finally, the injury or depression may be so severe that the infant cannot adjust to extrauterine life, and dies.

The purpose of this communication is to review some of these physical and particularly medicinal aids which have been used in this latter situation.

General Principles

The preventability of asphyxia neonatorum seems appropriately to come first. Application of good obstetrical and anesthetic principles would greatly reduce the incidence of newborn asphyxia. The importance of proper utilization of analgesic and anesthetic agents, and of prompt obstetrical assistance when indicated, cannot be overemphasized. The severely narcotized child is a great problem and all the ministrations of man cannot re-

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verse the damage done to an improperly delivered after-coming head. Nevertheless, even in the best conducted labor and delivery, asphyxia of the infant will occasionally confront the physician.

In the past many measures have been employed to stimulate the apneic child, most of which cannot be recommended today. Many drugs have had their vogue, but few have withstood the critical test of time, some actually being more potentially harmful than useful. Many forms of physical stimulation (*e.g.* spanking, or immersing the unresponsive infant in baths, alternately warm and cold) are not recommended. Artificial respiration of various forms, including positive pressure maneuvers, are still recommended under certain circumstances.

Clear the Airway

The single most important principle in resuscitation of newborn, clearing the airway, was a ritual with the early Hawaiians. The grandparent had the duty of sucking the *nalu,* or fluid from the baby's nose, with his own mouth. Next the oral pharynx was wiped out with the finger, sometimes wrapped in a clean piece of tapa. Most of their other practices could not be recommended today. (They squirted a little of the mother's milk in each eye, in a fashion similar to our present day use of silver nitrate.)

A clear airway is absolutely necessary and can usually be established. Care must be taken that the suction does not injure the larynx and cause subsequent edema and obstruction. If the usual gentle oral-pharynx suction with bulb syringe is not adequate to clear the mucus, gentle suction with a soft rubber catheter attached to a De Lee trap under direct observation, using an infant laryngoscope, will generally be effective.

Assist Respiration

A flaccid, depressed infant may require endotracheal intubation, suction, and possibly artificial breathing. Of the various methods of artificial breathing, mouth-to-mouth breathing is the most readily available. There are positive pressure machines in general use, but if mishandled, these can be dangerous. Familiarity with the apparatus and with the dynamics of infant pulmonary function are essential for the successful use of these methods. Benefit from the standard methods of artificial respiration by intermittent compression of the thorax lies chiefly in the resulting cutaneous stimulation. Generally in the apneic, flaccid infant, as the thorax is compressed, the abdomen is distended, with little or no net air exchange.

Oxygen is useful in resuscitation of the newborn but it will not initiate respiration by itself. A gentle flow through a mask or tube placed near the mouth will be adequate. In mouth-to-mouth breathing, a gentle flow of oxygen into the operator's mouth may be helpful. Gastric instillation of oxygen cannot be recommended, despite its widespread use in Europe. Carbon dioxide is not useful in resuscitation of the newborn in the delivery room. Gentle cutaneous stimulation will start most normal infants breathing spontaneously; and while slapping the buttocks or soles is traditional, firm rubbing of the back, from the buttocks up, eliciting the Perez reflex, is probably most efficient.

Drugs Recommended

Of the drugs which are sometimes used today, the following may be helpful:

1. *Caffein* usually is used as an equal mixture of caffein and sodium benzoate. Caffein actually has no direct action on the respiratory center except in very large doses. It is a general cortical stimulant, however, and is said to cause an increase in cardiac output and coronary blood flow. In sufficiently large doses it causes convulsions at the cord level similar to tetanus. Its margin of safety and comparative innocuousness make it the safest stimulant in use.

2. *The morphine antagonists* (Nalline and Lorfan) are substituted morphine molecules and are specific antagonists to the respiratory depressive effects of the opium derivatives (morphine, Demerol, Nisentil, Dilaudid, codeine, etc.) but not to those of the barbiturates or volatile anesthetic drugs. In the presence of the opium drugs, the respiratory depression is specifically and selectively antagonized without diminishing the analgesic effect of the narcotic. *In the absence of the opiates, or in incorrect dosage, these drugs are primary C.N.S. depressants.* They can be useful in the prevention of severe narcosis in the infant when used in the mother before delivery, as when mixed in the proper ratio with the narcotic before injection, or when given separately in time to cross the placental barrier (about 1-5 minutes after IV injection). It is also useful in the infant depressed by opiates, by injection into the umbilical vein. *If the depression is not due to opiates, they will only further depress the respiratory center.* The suggested dose of Nalline in an infant is 0.1-0.2 mgm by vein, and after injection the response should occur in about one minute; the dose may be repeated if necessary.

Nalline is available as a 5.0 mgm/ml preparation (for adults) and 0.2 mgm/ml preparation (for infants). The higher concentration should not be used in infants because of the great difficulty in measuring the small dosage during the emergency. Nalline is a regulated drug under the Harrison Narcotic Act. Lorfan is a salt of the

morphine derivative and is not regulated by the Narcotic Act. Its pharmacology is essentially the same as Nalline's except for the smaller dose required. It is available as 0.05 mgm/ml (for the infant) and 1.0 mgm/ml (for the adult).

Drugs Not Recommended

The following preparations, though sometimes used, are not recommended:

1. *Alpha-lobeline* was probably one of the most widely used drugs in the past. It cannot be recommended today because further study has failed to substantiate its usefulness in the newborn infant. Goodman and Gilman, and Lim and Snyder, consider it not only ineffective, but actually dangerous. It acts primarily on the medulla, stimulating probably the respiratory and vagal centers. The vagal center in turn causes vomiting, cardiac slowing, and fall of blood pressure. The margin of safety is very narrow, in overdosage it acts as a primary central nervous system depressant and is reported to have a curare-like effect on motor nerves. The dosage recommended in the older textbooks is 3 mgm repeated as necessary. Alpha-lobeline is currently available in 10 mgm ampules, a total dose quite excessive for an infant.

2. *Nikethamide* (Coramine) or nicotinic acid amide has most of the properties of nicotinic acid. It stimulates the medulla directly and via the sinoaortic chemoreceptors. This stimulation is then followed by a relative depression, especially of the central nervous system and respiratory mechanisms. It may transiently elevate the blood pressure in some instances. The margin of safety between effective stimulation and convulsive levels is narrow.

3. *Picrotoxin* is a mixture of picrotin and picrotoxinin, the latter a primary convulsant. In normal subjects, subconvulsive doses have no discernible effect. In depressed subjects, however, especially in depression due to barbiturates, a subconvulsive dose does appear to stimulate respiratory function. There is a delayed period between injection (i.v.) and onset of activity of 10 to 15 minutes. This delay makes this drug useless in stimulating onset of respiration in the newborn, where 10 to 15 minutes are decisive. The delayed onset of action has also been responsible for overdosage in many cases.

4. *Ethyl-methyl-glutarimide* (Megimide *et al.*) was originally claimed to be a specific antagonist to barbiturates. It is not. It is a primary central nervous system stimulant with a fair margin of safety, overdosage causing convulsions. The site of action is not well known as yet.

Summary

In summary, the following recommendations for the care of the newborn infant can be made.

Use good obstetrical and anesthetic principles to prevent depression and damage to the child.

Use the proper mixtures of Nalline or Lorfan *with* the narcotic chosen for analgesia; the analgesic property of the drug will remain the same but the respiratory depression will be lessened. If a mixture has not been used and the mother is unintentionally narcotized too close to time of delivery, use the antagonist drug before delivery, if possible. Use the narcotic antagonists in the infant *only* when definitely indicated by depression due to opiates.

As soon as the infant is born, clear the airway. Use gentle stimulation and oxygen as necessary. Reserve endotracheal intubation and positive pressure breathing for those who demonstrate a real need for such measures.

The various other medicinal stimulants cannot be recommended. If the physician feels he must use something, caffein and sodium benzoate would be the safest choice.

Pain and bleeding revealed the presence of this rare and puzzling gastric neoplasm.

Granular Cell Tumor (Granular Cell Myoblastoma) of the Stomach

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IT IS OUR purpose to report a granular cell tumor of the stomach which caused epigastric pain and massive gastrointestinal hemorrhage. It is, to the best of our knowledge, the second such tumor to be reported and the first of its kind that caused symptoms.

Case History

This 40-year-old Hawaiian man had indulged heavily in alcohol over the past four years. During this period he experienced attacks of sharp epigastric pain which radiated to the back. He stated that he had passed dark stools on three occasions. He had taken antacids only on rare occasions and with little relief. Three days prior to admission he lost his appetite and had some pain in the abdomen. On the day before admission, he passed dark stools. Several hours before coming to the hospital, he vomited a large amount of fresh blood and noted bright blood in a bowel movement. The pain was very sharp and was well localized to the right of the epigastrium.

The physical examination was not remarkable except for the initial shock state. There was no jaundice and the skin showed neither spider nevi nor any of the stigmata of von Recklinghausen's disease. There was slight tenderness to deep palpation of the epigastrium and no masses were felt. Bowel sounds were active.

Red cell count was 3.3 million; hematocrit 31.5%; white cell count 9,500. Urinalysis was normal. BSP retention was 16%. Prothrombin time after transfusion was 81% of normal.

The patient's blood pressure was 90/60. He was pale, had tachycardia, and suffered from extreme thirst. An intravenous infusion of 6% Dextran was started, and the patient was given 1000 cc of whole blood. His blood pressure rose and stabilized at 130/90. Nasogastric suction produced a small amount of bloody drainage at first, turning clear of blood after several hours. On the second day the patient had a massive bowel movement containing a large amount of blood. Because of this, he was taken to surgery without any further diagnostic investigation.

At the time of surgery there were no peritoneal adhesions and there was no evidence of increased portal pressure. The liver was grossly normal. There was no evidence of duodenal or gastric ulceration. The small bowel contained blood beginning three to four feet distal to the ligament of Treitz. There were no gastric varices. There was a discrete submucosal mass on the posterior wall of the gastric fundus. The lesion was oval with smooth borders and covered by intact, but vascular, mucosa. In the absence of any other source of bleeding it was decided to perform a distal subtotal gastrectomy, so as to include the mass just described. Approximately 70 per cent of the stomach was resected. The postoperative course was entirely satisfactory with the patient tolerating feedings on the third postoperative day. The patient remained completely asymptomatic and returned to work in the sixth postoperative week.



DR. STEMMERMANN

Pathologic Findings

On opening the stomach no mucosal ulcers were found. There was a firm, oval yellowish tan mass in the fundic submucosa, 4 mm from the proximal cut edge of the specimen and 1.1 cm in diameter. The mass was fixed to the mucosa, but freely movable over the muscularis externa. The covering mucosa had a hemorrhagic, granular appearance.

Microscopic examination of the mass revealed it to be composed of groups of plump cells. These had an abundant, well-defined, eosinophilic, granular cytoplasm. Their nuclei were fusiform and plump. They showed moderate variation in size. They extended into the lamina propria (Fig. 1, 2, 3). The muscularis mucosa could be identified as a well defined layer extending throughout the entire superficial portion of the mass. Its cells merged imperceptibly with the mass. Where the tumor bordered the submucosa, tongue-like projections of similar tissue extended into the surrounding stroma. These elements bordered but did not blend with the blood vessels of the area. Small groups of tumor cells were also found to be associated with submucosal nerves located at a distance from the main tumor mass (Fig. 4). The mass extended to within a short distance of the mucosal surface. The lamina propria in this area contained a large number of greatly dilated blood vessels. Sections taken from the remainder of the stomach revealed the mucosa to be well preserved. There was no evidence of inflammatory change within the mucosa of the pylorus.

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Granular Cell Myoblastomas of Intestinal Tract, Rectum and Anus
Laboratory of Surgical Pathology—Columbia University—1940-1960

PATH NO.	SEX	AGE	SITE	SIZE	CELLS IN NERVES	REMARKS
P&S 34724	M	45	Submucosa muscularis and mesentery of appendix	1.5 cm.	None seen	Cells often follow or surround capillaries
P&S 34725	F	15	In muscularis of appendix	Microscopic	None seen	Chance finding—op. for ruptured ovarian cyst
A-37068	F	50	Appendix, submucosa	Microscopic	None seen	Chance finding
P&S 60922	?	?	Appendix, submucosa and muscularis	?	Slide not available for review	
P&S 22199	M	30	Perianal skin	2×1.7 cm.	None seen	
P&S 48387	M	28	Anal canal 1 cm. inside sphincter, submucosa and muscularis mucosae	5 mm.	None seen	
P&S 50098	F	Adult	Probably rectal; muscularis present and rectal gland	?	None seen	Tissue passed per rectum
P&S 60921	?	?	Cecum-pedunculated tumor involving muscularis mucosae and submucosa	?	Slide not available for review	
P&S 40464	M	37	Ascending colon, submucosa. Looked like projecting sessile polyp	1.5×1 cm.	None seen	Chance finding at autopsy

Discussion

The tumor noted in this patient resembles that which Abrikossoff[1] first called "Myoblastenmyome" in 1926. He had five tumors of this type: three from the tongue, one from the upper lip, and one from the gastrocnemius muscle. He felt that they arose from striated muscle following degeneration, trauma, and inflammation.

In a subsequent paper he noted that dysontogenic inclusions of primitive myoblasts might serve as sources of tumors in areas devoid of skeletal muscle. This is an important addition to the concept that these tumors arise from striated muscle, since they have been reported from a large number of sites that contain no such tissue. Among these there may be mentioned skin, breast, uterus, broad ligament, urinary bladder, gastrointestinal tract, gingiva, and stalk of the hypophysis. Tumors arising from the gastrointestinal tract between the esophagus and the anus are distinctly unusual. Murphy *et al.*[2] noted none in their review which included 229 such tumors reported up to 1948. The files of the Department of Surgical Pathology, Columbia University College of Physicians and Surgeons, contain ten such cases as of August, 1960 (stomach 1, colon 1, cecum 1, appendix 4, rectum 3). The details of the non-gastric cases are included in a table which was supplied to us by Dr. A. P. Stout.[3] The gastric tumor has been separately described and illustrated by Stout.[4]

As more non-muscular sites were reported it was inevitable that a variety of cell types would be suggested as the source of these tumors. Abrikossoff's concepts, however, were strengthened by Murray.[5] She noted a closer resemblance between tissue cultures derived from these tumors to those from normal or neoplastic skeletal muscle, than to cultures of other tissue types to which their origin had been attributed. Among the latter she included xanthogranulomatous tissue, salivary gland myoepithelium, and nerve tissue.

The tumor in this patient was closely associated with nerve fibers. Some nerves outside the main mass contained clusters of granular cells and a neurogenic origin is at least suggested by this finding. Fust and Custer[6] proposed that these tumors arose from nerves because: (1) They could demonstrate concentric masses of granular cells with cores consisting of bundles of axis cylinders. (2) Clumps of tumor cells occurred singly or in small clumps within the sheaths of nerve twigs at some distance from the tumor proper. (3) Certain tumors display a general pattern reminiscent of peripheral nerves, with the cells arranged in fasciculi and separated by delicate wavy fibrillae. (4) Some tumors show many features of the conventional neurofibroma, but in which the granular cell component was progressively greater. Subsequently Pearse,[7] Ashburn and Rodger,[8] and Bangle[9] have presented evidence in support of a neurogenic origin. Pearse[7] felt that fibroblasts, including those of the perineurium and endoneurium, undergo a granular degenerative process and are thereby transformed into myoblastoma cells. Bangle[9] felt

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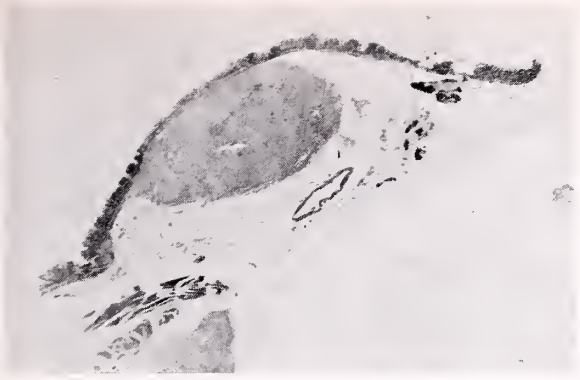


FIG. 1.—*Granular cell tumor, stomach, showing relationship to mucosa.* × 4

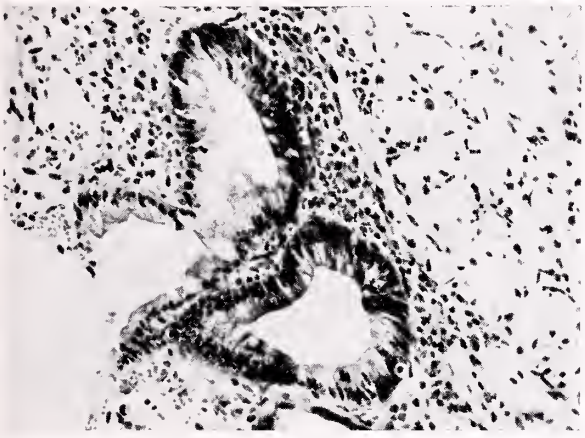


FIG. 2.—*Granular cell tumor, stomach, showing relationship to gastric glands.* × 265

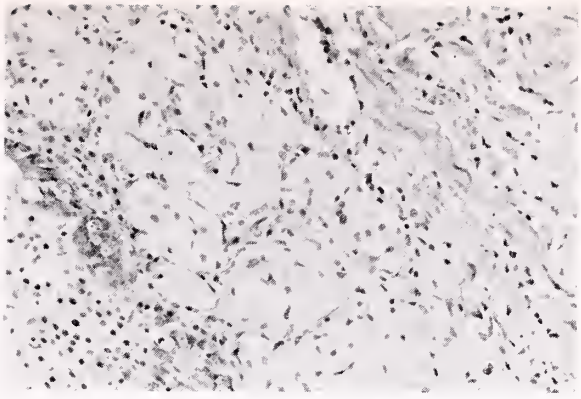


FIG. 3.—*Granular cell tumor, stomach, showing relationship to muscularis mucosa.* × 265

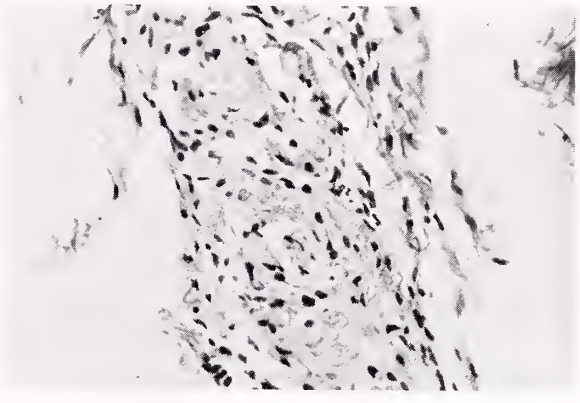


FIG. 4.—*Granular cell tumor, stomach, showing tumor cells associated with submucosal nerves in an area remote from the main tumor mass.* × 265

that the structure of these tumors was reminiscent of plexiform neuromas. The stroma of the tumors contains discrete interstitial cells which contain intracytoplasmic angular bodies and coarse granules. He felt that these were possibly histiocytes. Histochemically the coarse granules of the tumor cells and interstitial cells contain lipids probably bound as lipoprotein and sphingolipid. Histochemically recognizable myelin is absent in myoblastoma cells. Subsequently Bangle[10] reported a tumor of this type which was confined within a small peripheral nerve. He felt that this substantiated the neural origin of these tumors.

We have recently received a summary[11] of A. P. Stout's current concept of these tumors that is so succinct as to merit being quoted verbatim: "I think one trouble with determining the etiology of the granular cells of these tumors has been that all the authors have felt that all these granular cell tumors come from one cellular origin. This is certainly not the case. The pedunculated granular cell tumors attached to the gums of newborn infants are of tooth germ origin; the granular cell tumors that are found in the stalk of the hypophysis may be of neural origin but what the cell is I don't know. Perhaps some of the granular cell tumors found partly inside peripheral nerves may be neurogenous but I cannot imagine what the cell is for it is not a Schwann cell as Murray has shown by tissue culture. There are also the malignant organoid granular cell myoblastomas which are certainly not derived from paraganglionic cells. Some of the granular cell proliferations found in the smooth muscle wall of the appendix may even be granular degeneration of smooth muscle cells."

In view of the lack of unanimity among those who have made intensive studies of large numbers of these tumors, we should be presumptuous if we were to give the neoplasm in this patient a more specific designation than "granular cell tumor." We do feel, however, that we should be permitted the personal opinion that its configuration bears a close resemblance of neurofibroma, and that the association of tumor cells with nerves widely separated from the main tumor mass strengthens the possibility of neural origin in this instance. The absence of nerve involvement in Stout's fairly large group of gastrointestinal granular cell tumors strengthens the possibility that these tumors are of diverse origin, and that the tumor in the present case is not a typical representative of the group.

Summary

1. A case of granular cell tumor of the stomach is reported which was associated with epigastric pain and massive gastrointestinal hemorrhage.

2. This is the second such tumor to be reported from this site and first to be symptomatic.

[10] Bangle, R.: An early granular-cell myoblastoma confined within a small peripheral myelinated nerve, Cancer 6:790-793 (July) 1953.
[11] Stout, A. P.: Personal communication.

The authors wish to acknowledge a deep sense of gratitude to Dr. A. P. Stout, Department of Surgical Pathology, Columbia-Presbyterian Medical Center, for his advice and assistance in the preparation of this paper.

This satirical sociological disquisition on a disease of our town in our time is worth reading twice if you didn't get its message the first time around

HMSA Disease

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HMSA DISEASE is an insidious and chronic disease of a group of peculiar humans called physicians, due to multiple causes, and characterized by peculiar behavior and somatic symptoms.

Etiology

The exact cause of HMSA disease has not been determined. Viruses and bacteria have been suspected, but all attempts to isolate a causative organism have been futile. Waite and Omura have suspected parasitic agents. Their efforts to prove their theory from autopsy material, by biopsies, and through numerous stool examinations have been negative.



DR. DICTU

Harris, Jacobson, and Haertig in their monumental work in 1948 discussed at length the possibility that the host physician had lost too much of the motivation to help others and had thus become susceptible to various environmenal factors. They demonstrated with guinea pig studies that their theory could have a sound basis; however, their theory was seriously questioned by Doolan in her report to the Governor of Hawaii in which she stated that "...guinea pigs are not human." Pauling, Sison, and Cottington, using suckling mice as experimental animals, demonstrated that perhaps inadequate nursing at the breast was a predisposing cause. They postulated that poor colostrum intake resulted in poor resistance to social diseases. Ohtani, Wong, and Lambert in a series of 1,000 deliveries found vestiges of HMSA disease in the placenta and in the amniotic fluid in exactly 27.8%. They strongly suspected a congenital transfer of the disease.

Gotshalk, Lowrey, and Bennett, working with pituitary glands of hamsters in an ingenious experiment in 1952, postulated that the Laymen cells secreted too much power hormone, thereby affecting adversely the target cells, such as the Hospital cells of the kidneys, the M.D. cells of the adrenal cortex, and the Consumer cells of the loop of Henle. The work of Cloward, Devereux, Felix, and Chang in the same year indicated that the power hormone of the pituitary was an abnormal one with an ethyl group replacing the methyl group on carbon 32. In 1954 Nance, Peyton, and Oglesby disputed the work of their predecessors and found that in human cadavers degenerative lesions are present in the cerebellum and suggested that the disease is one of lack of coordination. In 1955 Choy, Chun, Wong, Lum, and Tamura working in the ferret laboratory of King's Hospital produced disputable evidence that the bone marrow did not produce enough money cells.

In summary the exact cause of the disease is not known, but multiple causes are presumably at play.

Epidemiology

HMSA disease started in the slums of Honolulu in 1932, according to Larsen, Pinkerton, and Palma. It spread rapidly as far Ewa as Kaena Point and as far Diamond Head as Koko Head. It then spread rapidly mauka and makai. Enright and Lee, while working on the subject of pH of artesian well water, strongly suspected that the heavy rainfall in Dowsett Highlands was the driving force behind its rapid spread on the Island of Oahu.

It then spread to the Islands of Maui, Hawaii, Kauai, Molokai, and Lanai and strangely left Molokini, Kahoolawe, and Niihau free. Sugihara, Nelson, and Chun-Ming, while working with the Hawaiian Weather Bureau in 1957, produced conclusive evidence that the Kona winds carried the disease northward, and Myers, Moore, and Milnor showed that the trade winds carried the disease south-westward.

There were three cases reported from Portugal by Vasconcellos, nine from Canada by Hagino, thirteen from Japan by Nishijima, eighteen from Hong Kong by Nip, twenty-seven from Bali by Momeyer, twenty-three from Ireland by Bell, eighty-two from England by Watson, five from

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Australia by Hunter, and a questionable case from Pitcairn's Island by Beddow. These reports indicate a possible world-wide distribution.

Pathology

Larsen performed the first complete autopsy and found a grossly degenerated cerebellum, a hypertrophied pituitary gland, and a cardiac ensmallment. Price reported a series of 38 autopsies and corroborated Larsen's findings. In addition Price demonstrated multinucleated giant cells in the adrenal cortex, inclusion cell bodies in the red nucleus, and bilateral inguinal hernias in 58.6 per cent of physicians. Dictu, Marshall, Mertz, and Yim, using electron microscopy, demonstrated hyaline degeneration of the intercellular cement substance. Dictu and Pinkerton (1955) found hyperplasia of the Laymen cells of the pituitary gland, thus lending some support to the great experimental work of Gotshalk, *et al.*

Clinical Manifestations

HMSA disease is characterized by lethargy, antipathy, submissive dependence, negativism, excessive appetite, insecurity, hyperactive grasp reflex, phobias, risus sardonicus, palmar pruritus, and even suicidal behavior. Fever has never been an outstanding finding, but may be present. Pang, Pang, and Pang in their cooperative study in 1953 described one stricken physician wandering aimlessly in front of St. Joseph's Hospital muttering strange nothings to the student nurses. Arnold and Hartwell in 1954 described a case in which erythema multiforme was combined with myocardial degeneration. Natsui, Kepner, and Lo in 1954 demonstrated under hypnosis and oath that fear of retaliation and punishment was an outstanding subjective feeling. Berk and Henry have demonstrated huge, often multiple, ulcers in the duodenum and lesser curvature of the stomach. Nakasone and Fong have found slight to marked changes in the QTC, P-R interval, and S-T segment of the electrocardiogram. Ishii and Horio have reported systolic pressures to be high, diastolic pressure to be low, and pulse pressures to be wide. Johnson, Arnold, and Emura reported that the incidence of neurodermatitis in a series of 108 cases of HMSA disease was 88 per cent. One palm was involved in 76 and both palms in 24 per cent of those with neurodermatitis.

In periods of epidemics Pang, *et al.* have noted complete panic among the physicians with behavior comparable to that of stampeding cattle. They also noted that verbal diarrhea and a resistance to listening were frequently outstanding. In one epidemic it was noted that the physicians were blaming each other for their maladies and telling each other how to practice medicine. Some were found



treating each other's symptoms with drug samples obtained from detail men peddling their wares in the corridors of hospitals.

Diagnosis

In establishing a diagnosis a high index of suspicion is necessary based on the history and clinical manifestations. Psychiatric consultations may be of extreme value, for very often the clinical manifestations are bizarre and subtle, particularly early in the course of the disease.

Dictu's Test (1959), depending on the presence of circulating power hormone, may be positive.

Sakimoto's Test may be positive, doubtful, or negative. If doubtful or negative, it should be repeated over and over again until it becomes positive.

Goto's Test, for presence or absence of functioning M. D. cells of the adrenal cortex, may be of value, but is negative most of the time, and, if positive, may be of doubtful value.

Punch biopsy of the cerebellum using the modified Morgan and Yamamoto renal biopsy do-it-yourself kit may show the degenerative lesions as described by Nance *et al.*

Bone marrow smears using the technic of Jim as modified by Ando and Oishi and stained by Brown's Stain may demonstrate depression of money cell production.

Treatment

Medical management of HMSA disease should be initiated by combined socio-economic changes aimed at reactivating the basic drives of the host. The sick, sick physician should not be isolated but should be allowed to be up and around and to mingle with and to help the other sick, sick physicians on the ward with the hope that he may develop insight into his own problems. Fujiwara and Giles have shown that early ambulation results in more rapid recovery of the patient. Liberal visiting hours by his wife, children, minister, and friends may help reassure him that he can and will get

well. Sound-proofing of the ward, particularly against any sound resembling the jingling of money, the rustling sound of greenbacks and checks, and the ringing of cash registers, will be of considerable value. Ewing demonstrated the emphatic need for teamwork in getting the patient well. Tranquilizers in adequate doses around the clock have been advocated by some, particularly Doolittle and Beck. The Stockton regimen has been advocated as a panacea by DeHay. Skin manifestations have been symptomatically managed, but a cure can be expected only if the underlying disease is corrected.

Surgical management has varied from conservative to radical. Conservative neurosurgeons have advocated subtotal resection of the pituitary. Radical extirpation of the pituitary has been advocated by a few, but none of their patients have survived. Selective removal of the cells producing power hormone has been tried without success. Selective removal of the Hospital cells of the kidney and cauterization of the M.D. cells of the adrenal cortex have been advocated by Strode, Freeman, and Strode. Cauterization of the Consumer cells of the loop of Henle has been tried unsuccessfully by Koike and Morgan. Removal of the cerebellum has been tried by Lowrey and Cloward on two occasions; both patients expired without leaving a will. Richardson and Kutsunai have tried bone marrow transplants without any success.

Numerous preventative measures have been tried including Dickson's serum, Kaneshiro's AT37 antigen, Tyau's rabbit antiserum, Molyneux's polyvalent toxoid, and West's placental extract. All have failed to prevent the disease. Environmental studies by Sexton, Watt, and Sia strongly suggest that a good upbringing may prevent the disease. Yamashita and Nakamura have contradictory data.

Prognosis

The patient will not die of the disease if untreated and will not usually die if maltreated except in those instances in which extremely radical surgical technics are used.

Prognosis is good to excellent if conservatively treated with teamwork and long-term plans for gradual rehabilitation into modern society as shown by Shepard in 1959 in his famous monograph.

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The "cingulus" (belt) of shingles may occur in some unusual sites.

Zoster Facialis

A Case Report

JOHN R. CLARK, M.D., Honolulu

The illustrations were inadvertently omitted from the article by Dr. Clark which appeared in the last issue of the JOURNAL. They are published here with apologies.



FIG. 1—*Herpetic eruption over distribution of trigeminal nerve, mandibular branch.*



FIG. 2—*Peripheral facial nerve paralysis with epiphora of the affected eye.*



FIG. 3—*Resolving eruption with temporary facial weakness.*

The President's Page



DR. BURDEN

This coming year can be a very challenging year!

It can be a challenge to every member of the HMA to forget petty personal differences and group politics and try to work together for the mutual good of everyone and the advancement of good medicine.

It can present a challenge to those who have been "too busy" with practice and personal affairs to participate in the activities of the Association to get off their duff and start participating.

It can present a challenge to each of us to back up our main defense against the encroachments of socialized medicine, the voluntary prepaid health insurance plans. We should get behind the new "Stockton Plan," which shows promise of providing care in areas heretofore not adequately covered, and back it up with the support it deserves. In doing this we must not forget our own Blue Shield plan, the HMSA, which has done such an outstanding job in combating socialized medicine by providing top quality coverage with its various plans, each adapted to special conditions and special needs. We should get behind them 100% by stopping the "throat cutting" practice of accepting fees paid by other indemnifying commercial plans, paying lesser fees than the HMSA schedule, as payment in full. Groups or persons utilizing these plans will not change to HMSA as long as doctors accept the lower fees of these lower cost policies as payment in full. In all cases each doctor should charge his usual charge but not less than the fees allowed by HMSA.

We have a challenge to work together to make the Federal Employees Dependent Medical Care Program, the Government's entering wedge in its program for control of medical care, work and to improve it until it provides medical care compatible with good medical standards. This can only be done by implementing all provisions of the plan and not just part of them. As long as a large portion of the doctors remain satisfied with accepting the insurance portion of the fee allowed as payment in full, and refuse to pass on to the patient that portion of the fee supposed to be passed to the patient, in order to control overusage and at the same time allow the physician a just fee, it will be difficult if not impossible to prevent overusage of the plan or to negotiate improvements in areas where they are definitely needed. A recent spot survey showed that only a little more than one doctor in four was implementing the plan as it was supposed to be implemented. The other three were accepting less than the plan allowed, with many being satisfied with that portion of the fee covered by HMSA. This practice must be eliminated if we are to keep prepaid medical plans on a high level.

It would seem that many doctors are not interested in preserving our right to practice medicine as we see fit but are willing to let others dictate the terms under which we shall practice. There are many forces who would be more than glad to do this. The Government, the ILWU, and Mr. Kaiser are only interested in the type of medical care that they can control. They are not interested in better medicine but controlled medicine and unless we unite and exert as much energy in combating their inroads as they are we will soon find it too late to do anything about it.

Yes, this coming year offers a great challenge, for it can be a year of organizing, a year of preparation for what lies ahead. Only by concerted action can we obtain our objective, and quibbling and friction within our ranks will serve only to help the opposition. Every physician can help by joining the Physicians' League for Good Government and working to develop it into an effective non-partisan organization. Every physician should join the local unit of his own political party and actively participate in the activities of that unit. If this were done, the influence would be terrific. There would be little need for a public relations department to "sell us to the public" for it would already have been accomplished through the work of individuals.

Each of us must stand up for what he feels is right, but we must present a united front in defending what we know is right.

Mahalo!



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[EDITORIALS]

Foreign Medical Graduates and the Law

The only piece of medical legislation that survived the most recent *hoopaapaa* in Iolani Palace was Act 72, amending the Medical Practice Act as it relates to foreign medical graduates. The unreasonable obstacles to their licensure here have been removed—but many still remain. We are not about to become a haven for displaced immigrant physicians.

Our law still provides no licensure by reciprocity, except for diplomates of the National Board Examination; and a year's legal residence in Hawaii is still required of all candidates.

Any physician, otherwise qualified, who has practiced for seven out of the eleven years immediately preceding his application as a licensed physician in another jurisdiction, may be admitted to examination for licensure in Hawaii. The old law required ten years of such practice; the new one requires seven because one politically influential candidate could only furnish seven. One can hope that misplaced compassion was the only motive for making this change in the law.

A foreign graduate who cannot qualify under this provision may be admitted to examination for licensure if

(1) He has applied for, or achieved, U. S. citizenship;
(2) He has the permanent certificate of the ECFMG (Educational Council for Foreign Medical Graduates) examination; and
(3) He has had three years of internship or residency training in a hospital approved for such training by the Council on Medical Education and Hospitals of the American Medical Association.

The other requirements applying to all applicants —two letters certifying to his good moral character; a visit to Hale Mohalu; and so on, remain in the law.

The ECFMG examination is a tough one—according to Dr. Perrin Long, too tough. Up to a year ago only 40% of candidates taking it had achieved a passing grade of 75% or higher. Almost an equal number failed. The remainder were given the "temporary" certificate, good for two years, and not renewable.

According to Willard Rappleye (*Hospitals*, February 16, 1961) about three per cent of the 12,000 foreign graduates serving as interns or residents in American hospitals are citizens, and ten per cent are aliens with immigrant visas. The remainder are on student or exchange visitor visas and must, under Public Law 555 of the 84th Congress, reside out of the United States for two years before they can change their status to that of a permanent resident or be granted an immigrant visa.

Under Hawaii's new law, a substantial though not an overwhelming number of foreign medical graduates will probably be examined in each session, in equal competition with graduates of American and Canadian schools. Many of them have not had a first rate medical education during their undergraduate years, but have worked hard to make up for it. They deserve well of us who have been more fortunate. We wish them well.

"A Gentleman with Clean Hands"

The idea that an apparently healthy person can transmit disease was perhaps first propounded by Ignaz Semmelweiss, who said of puerperal fever that "a gentleman with clean hands may carry the disease," and was harried into an early grave for his boldness.

The bind was a semantic one, of course. What is "clean?" In this case it meant free from visible dirt but not from invisible streptococci.

We are learning now that a gentleman (or lady) with clean blood, so to speak, may carry diseases of blood. Specifically, a person with "normal" hemoglobin may confer serious anemias of various kinds upon his offspring.

Again the semantic question is posed: what is meant by "normal" hemoglobin? In this case, it means hemoglobin of normal redness and amount, but abnormal electrophoretic mobility and molecular structure.

"Normal" hemoglobin is hemoglobin F in the fetus, hemoglobin A (and a little A_2) in the adult. The differences, as with the abnormal ones, are found in the two pairs of polypeptide chains (α and β) composing the globin portion of the molecule. The structure of these chains is under genetic control, and is therefore affected by mutations and by inheritance.

The first abnormal hemoglobin, identified by Pauling and associates in 1949 in sickle cell anemia, bears the designation S. Its molecular formula, instead of being a normal $\alpha_2{}^A\beta_2{}^A$, is $\alpha_2{}^A\beta_2{}^S$ ($\alpha_2{}^A\beta_2{}^{6val}$).

Abnormal hemoglobins discovered since 1949 have been assigned letters of the alphabet in order, starting with C (because B had been briefly preempted to designate fetal hemoglobin, subsequently labelled F) and adding the country or city of origin as a subscript where necessary. Thus there is a hemoglobin $G_{Philadelphia}$, hemoglobin $G_{San\ Jose}$, and even a hemoglobin $G_{Honolulu}$, described by our own Dr. Robert Jim.

The 26-letter alphabet has proved unequal to the task, now, and new hemoglobins are being named for the institution, city, or country of origin: hemoglobin Barts (for St. Bartholomew's Hospital), hemoglobin Hopkins No. 1, and so on.

Many "well" persons (but not, so far, any Japanese!) have some normal and some abnormal hemoglobin, having inherited a normal gene from one parent and an abnormal one from the other. They are heterozygous for the defect: they are healthy carriers of the disease, if any, which characterizes the abnormal hemoglobin molecule in question. These people can be identified by their possession of two kinds of hemoglobin, differing in their rate of electrophoresis. It may ultimately be possible to identify such individuals by examining their chromosomes, the study of which is another significant frontier of research.

"A gentleman with clean hands" may indeed carry the disease!

This is What's New!

Interferon is an animal protein that interferes with the growth of viruses. It is not an antibody, and although a protein it cannot stimulate the formation of antibody. It appears to go thus: virus invades tissue cell; cell releases interferon; the interferon prevents the production of adenosine triphosphate (ATP). Without energy-yielding ATP, the virus is stopped dead in its tracks! Interferon appears to be the explanation for hypo-gammaglobulinemic patients' withstanding viral infections much better than bacterial infections; for in these patients, although antibody titers are extremely low, the interferon production is normal. Thus far, interferon has proved effective in combating virus infections involving rabbit eyes and skin and generalized virus infections of mice. (*Scientific Am.* [May] 1960.)

A. P. Joslin, reflecting over his lifetime work in **diabetes,** makes some very interesting observations. Because of increased ability to successfully manage diabetes and the ability of pregnant diabetics to successfully complete their pregnancies, the **incidence of diabetes has greatly increased** during his medical career and will continue to increase in the future. He believes that all **diabetes is hereditary** and that obesity and oither factors are merely precipitants.

The most revealing figures, however, are the changes in the **causes of death** of diabetes over the past 50 years. In the present era, 64 per cent of diabetics died in **coma,** and shortly after insulin over half the deaths were due to **tuberculosis.** Today tuberculosis accounts for only 0.2 per cent of diabetic deaths, and death from coma has dropped to 1 per cent. In sharp contrast, however, cerebral-cardiorenal **vascular disease has increased** from 18 per cent to 78 per cent over the last half century; and diabetes causes more **blindness** in Massachusetts than any other single disease. (*Diabetes* [Mar.-Apr.] 1961.)

At the Massachusetts General, Robert Long and Oliver Cope found a high incidence of **preinjury emotional disturbances** in **severely burned children.** Frequently, the preburn psychological difficulties hindered recovery. If the emotional reaction is not recognized and adequately treated, prolonged hospitalization, failure of skin grafts, and intensification of the psychological disturbance often resulted. (*New Eng. J. Med.* [June 1] 1961.)

American children are as physically fit as European children—in certain parts of Europe. The **work capacity** of school children in Philadelphia, Germany, and Sweden was compared. The German and Philadelphian children were quite the same but the **Swedish children were superior** to both groups in work capacity. (*Arch. Environmental Health* [May] 1961.)

Six patients operated upon for **angina pectoris** appeared to benefit from coronary **thromboendarterectomy.** Relatively short-term followups at St. Johns Hopkins are encouraging enough to recommend this procedure in the treatment of certain patients with intractable angina pectoris. (*Postgrad. Med.* [May] 1961.)

A group in Mexico City investigated tests to differentiate **diabetes insipidus** from **compulsive polydipsia.** The most definitive test consisted of administration of **pitressin** I.V. immediately **after dehydration.** If the pitressin produces a more concentrated urine than dehydration, the patient has diabetes insipidus; if not, compulsive polydipsia is the cause of the signs and symptoms. (*Ann. Int. Med* [Apr.] 1961.)

At the University of California, an attempt has been made to determine the **prognosis of essential hypertension treated conservatively.** "Conservatively" in this series means treatment with mild sedation, occasionally with Rauwolfia alkaloids, sodium restriction, and weight reduction. At the end of five years, approximately one-third of the patients were dead, with the men having a significantly higher mortality than the women. Oddly enough, patients with clinical obesity were found to have a lower mortality than patients who were not obese. (*Circulation* [May] 1961.)

Should **anticoagulant therapy** be discontinued in a patient who is undergoing **dental surgery?** Twenty patients undergoing dental surgery did not have their anticoagulant discontinued and did perfectly all right with no unusual hemorrhage. The author suggested that anticoagulant therapy be held in the low optimal range; that is, 20 to 25 seconds with the normal of 15 seconds. (*J.A.M.A.* [Feb. 11] 1961.)

FRED I. GILBERT, JR., M.D.

ADVERTISEMENT

THE GUIDING PRINCIPLE OF HMSA



Twenty-three years ago, the social worker, school teacher, doctor and other community-minded founders of HMSA established the principle of dedicated Community Service which has guided the Association to remarkable growth and public acceptance.

Over the years, many individuals have worked unselfishly to carry out the Community Service Goal of HMSA: Physicians, Hospital Representatives, Board Members, Plan Administrators and their Staffs.

Today HMSA (over 40 percent of the people of Hawaii participating in their own, voluntary, free choice medical program) is living proof that a Community Can Solve Its Own Medical Economic Problems.

By steadfastly following its Community Service Goal of serving the people of Hawaii, HMSA believes it is making a significant contribution toward preservation of "free choice of Physician and Hospital."

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H.M.S.A. is dedicated to proving that a community through the cooperative efforts of its people, physicians and hospitals can best solve its own medical economic problems.

HAWAII MEDICAL SERVICE ASSOCIATION

Book Reviews

★The Metabolic Basis of Inherited Disease

Editors: Stanbury, J. B., Wyngaarden, J. B., and Fredrickson, D. S. $30.00, McGraw-Hill Book Co., 1960.

With 46 contributors, this book could have been a hodgepodge. It is not. The editors have done a superb job of organizing the well-written contributions of top investigators into a most readable text.

Even the clinician who takes some pride in being medically up to date will find this book an eye opener. Unless one has undertaken the impossible task of reading far afield in clinical journals, he is only dimly aware of the amazing progress that has been made over the past decade in understanding the biochemistry and genetics of "the inborn errors of metabolism." Although only those diseases in which the biochemical-genetic pathways are fairly well worked out are discussed, the obvious question that appears in the reader's mind is "What medical disease *does not* reflect some inborn error or defect?"

The cost is high but any book that significantly changes a physician's concept of basic disease processes is worth this price.

FRED I. GILBERT, JR., M.D.

Shaw's Textbook of Operative Gynaecology

Revised by John Howkins, M.D., M.S., F.R.C.S., F.R.C.O.G., 484 pp., $20.00, Williams & Wilkins Company, 1960.

A comprehensive and beautifully illustrated guide to operative gynecological procedures. Illustrations from Peham and Amreichs' textbook have been used extensively, although the preface to the second edition states "illustrations have been drawn by Mr. Leslie Caswell." The book is valuable as a reference and guide to daily gynecological surgical procedures. Since most gynecologists in our area tend to favor the operation for marsupialization of cysts of Bartholin's gland rather than the excision we formerly used, one wonders why this is not mentioned. Most of us in America will make little use of the chapters concerned with extensive surgical procedures on advanced cervical carcinoma. The author is to be congratulated on producing an extremely useful guide which all other up-to-date gynecologists should use to supplement their daily reference periodicals.

H. E. BOWLES, M.D.

Fundamentals of Clinical Hematology

By Byrd S. Leavell, M.D., 497 pp., $10.00, W. B. Saunders, 1960.

In hematology, the understanding of basic mechanisms of the diseases and the knowledge of the laboratory aspects are very important. It is a difficult task to condense these and still cover the subject adequately. The material is well organized and comprehensive. The case presentations appear to complement the discussions. The book should be a delight to medical students, for whom it was primarily written. The busy practitioner interested in reviewing the subject will undoubtedly find this book of value.

PAUL Y. TAMURA, M.D.

★Demonstrations of Physical Signs in Clinical Surgery (13th Edition)

By Hamilton Bailey, F.R.C.S. (Eng.), F.R.S.E., F.A.C.S. 928 pp., $14.50, The Williams & Wilkins Co., 1960.

This thirteenth edition is an up-to-date, compact, authoritative, and comprehensive compilation with 1,142 excellent illustrations of diseases common and uncommon in daily medical practice. The author gives a good picture of his aims, ideals, and method of presentation, important not only to the student but also as a guide to the qualified surgeon and practitioner. This book will give to the reader a clear picture and enable him to acquire familiarity with the diseases presented and discussed.

I consider this book well organized, the clinical signs well substantiated with illustrations, and an important adjunct to the diagnosis of any particular disease. I highly and unhesitatingly recommend it as valuable reference material.

M. J. AVECILLA, M.D.

Cardiac Resuscitation

By J. Willis Hurst, M.D., 141 pp., $5.50, Charles C. Thomas, 1960.

This is an excellent book for all physicians to read and know. It deals with all phases of cardiac resuscitation, explaining in detail its cause, effect, and treatment, from the various viewpoints of the internists, surgeons, anesthesiologists and even the legal and moral aspects. In it is contained some basic instructions in resuscitation that all physicians should learn well for very practical reasons. The reading is simple and clear and does not entail hours of references to explain itself. One might say that it's a good manual for cardio-respiratory resuscitation.

CLIFFORD K. W. CHOCK, M.D.

★Fundamentals of Chest Roentgenology

By Benjamin Felson, M.D., 301 pp., $10.00, W. B. Saunders Company, 1960.

When you look at a chest film, have you ever been perplexed by a shadow or density? What it represents? Where it is situated? Why it is there? Or how it was formed? Doctor Felson ably clarifies these questions in his book.

This short, readable book, filled with excellent illustrations and a long bibliography, should be a text for beginning roentgenologists and on the bookshelf for all interested in the interpretation of chest films.

Although the title is inclusive, the contents do not deal with soft tissue, osseous, or cardiac problems. Addition of these subjects in the same concise manner will certainly be appreciated.

TETSUI WATANABE, M.D.

★The Child with Mongolism (Congenital Acromicria)

By Clemens E. Benda, M.D., 276 pp., $9.50, Grune & Stratton, 1960.

This book is based on almost a quarter of a century of research, carried out in the research departments of

(Continued on page 600)

★ means highly recommended.

Notes and News

Congratulations to—

Dr. Samuel D. Allison, on his election as President-elect of the Waikiki Rotarians.

Dr. Max Levine, former chief of the State Health Laboratories, was one of the first eight who received certification as diplomates of the American Academy of Microbiology.

"Jack-Pot"—on the fourth try! **Dr. George H. Mills** announced the birth of Elsa Marjory Puanani on May 29.

Dr. J. Alfred Burden, President, and **Dr. Frederick L. Giles,** President-elect, of the Hawaii Medical Association.

Dr. Joseph T. Nishimoto was honored by the HMA at its annual meeting by being selected the recipient of the A. H. Robins Company award for outstanding community services. Dr. Nishimoto was also the recipient of the State House of Representatives' resolution commending him for winning the award.

Best wishes for **Dr. R. Y. Sakimoto,** recently appointed and confirmed, Oahu Police Commissioner. Doctors hope to get a "break" *now* on tickets??? [Not with our new traffic law!—ED.]

Dr. Teru Togasaki, who has been elected President of the League of Women Voters of Honolulu.

Dr. Peter Kim, administrator and medical director of Kauai's Mahelona Memorial Hospital, for his promotion to Lieutenant Colonel in the National Guard.

Fifteen island medics earned medical specialists certificates recently. They are **Drs. Ruth Oto,** Hilo; **J. D. Huitt,** Kailua, Oahu; **F. A. Munson,** Waialua, Oahu; **J. Lambert, C. Mason, V. Mori, I. Nadamoto, A. C. Oglesby, J. Ohtani, C. Sia, W. Strode, J. Watson, Dorothy Whittaker, Pablo Zamora,** all of Honolulu.

Dr. William N. Bergin, past HMA president, was elected nominee for Rotary International District 500.

Another past president, **Dr. Toru Nishigaya,** assumed the presidency of the Oahu Health Council.

Governor Quinn's nominees for various State posts included **Dr. M. A. Brennecke** (Kauai), State Board of Health; **Dr. P. M. Crockett** (Kauai), reappointed to the State Board of Medical Examiners.

Names in the News

Dr. Wallace Loui attended the AMA Medico-Legal Symposium in New York City April 28 and 29.

Dr. Thomas Chang took in meetings in New Orleans and stopped off in Las Vegas where he was seen and reported by a local columnist. Wonder if he made expenses???

Dr. and Mrs. Harold Moffat are traveling in Europe this summer. Medical meetings are conveniently scheduled in Barcelona and Paris.

Dr. J. Kometani and family left on the Lurline for an extended two-month trip.

Dr. Richard Dodge left for Saigon where he will participate in Medico's rotating physician plan to provide medical care to Indonesia.

Hawaii doctors attending the AMA meeting in New York included **Webster Boyden, O. D. Pinkerton, J. A. Burden, Harry L. Arnold, Jr., Richard D. Moore, L. Q. Pang, Leo Bernstein, Marvin Brennecke, Louis L. Buzaid, Raid Chappell, C. K. W. Chock, K. H. Ho, W. J. Holmes, Peter Kim, John T. Kometani, Thomas M. Mar, Clifford Mirikitani, A. V. Molyneux, Joseph Palma, A. K. Wong,** and **R. W. You.**

The recent HMA's annual meeting, May 4 to 7, received good press coverage; the work of our P.R. director, **Hugh Lytle,** was clearly noticeable.

Plastic surgery was discussed on KONA-TV. Panel members who ably presented their views were **Drs. Fernandez, Jim,** and **Wong.**

The open heart surgical team of The Queen's Hospital received excellent publicity through columnist Bob Krauss. Also rave notices on two successful operations on the two sisters from Guam. The headline read "Isle Heart Team Scores Double Win." Batting average going up!!!

Dr. Nicholas Steuermann has been invited to present a paper in Rome by the Council of International Organization of Medical Sciences.

Dr. Richard You, always an active participant, made a few splashes in his role of University of Hawaii regent for offering to underwrite the football program, and for his suggestion to keep the East-West Center separate from the University, but under the Board of Regents.

The HMA received quite a rap from union boss Arthur Rutledge who said "Some island physicians are cheating on union and health insurance."

"Hospital Costs Going Up? Of course, Say Officials"—so read recent headline. **Dr. Sumner Price,** ex Queen's administrator, and present boss man, Will J. Henderson, said costs will have to go up to meet the rise in wages.

The *Maui News* lambasted the profession in an editorial under the caption "Inviting Abuses" (commenting on the dog pound law favored by the profession). **Dr. Hartwell,** HCMS president, ably countered the editorial which the *News* printed.

Pacific Medical Associates are still making news. This time a voluntary dissolution.

A local newspaper headlined methotrexate as "New Drug Arrests Type of Cancer." **Dr. Tilden** had much explaining to do. Ditto **Drs. Batten** and **Quisenbery.**

Dr. H. P. Kramer, Medical Director at Kalaupapa Settlement, has resigned. Local health officials are having a difficult time finding replacement.

Dr. Norman R. Sloan attracted attention of the press when he recently said that too low salaries are hampering the State Department of Health in taking advantage of Federal aid, and may jeopardize future efficiency of the entire department.

Dr. Walter C. Alvarez (ex Mayo Clinic) had a reunion with old friends, **Drs. N. P. Larsen** and **F. Lam, Sr.**

Kauai doctors approved a unique plan recently—as part of the booking procedure at the Police Station, all vagrants and drunks will get an automatic chest x-ray.

Dr. Gordon E. Nielson of Laie blasted City and State Health Departments for inadequate emergency services and care for the poor.

The Leeward Oahu Hospital and Clinic will get a new building, so states **Dr. P. H. Liljestrand.**

New Affiliations

The Fronk Clinic has moved, lock, stock, and barrel, to its new offices at 829 So. Beretania St.

After many, many years **Drs. Culpepper** and **Bailey** have moved to a new location, 1451 So. King St. Cully's office was a landmark on Emma Street but had to make way for progress in the down town area.

The Clinical Associates at the Medical Arts Bldg. have dissolved. **Dr. D. C. Choy** is now relocated at 1124 Koko Head Ave. The others, **Drs. Tanoue, Ishii, Horio,** and **Yoshida,** are still holding forth on an individual basis at 1010 So. King.

Dr. R. K. B. Ho too has gone independent and is now located at 1415 Kalakaua Bldg.

Dr. J. T. Leong announces removal of his offices to the Central Medical Bldg.

Dr. Ross Y. Hagino is soloing at 2080 So. King St.

Dr. P. M. Corboy has also relocated. His new offices are at 305 Royal Hawaiian Ave.

Dr. Robert Lee, Jr., has joined his dad in practice at 1123 Koko Head Ave.

Dr. Donald Depp has pulled up anchor and will move to "America." Ditto **Dr. Kenneth Rusch** who will leave in July.

Dr. Wally Herter is now practicing on Kauai.

BARNEY NOBORU IWANAGA, M.D.
1906-1961

Barney Noboru Iwanaga was born August 31, 1906, in Honolulu. He attended McKinley High School and the University of Hawaii, and received his M.D. in 1934 from the College of Medical Evangelists. He returned to Honolulu to practice medicine after an internship at Orange County General Hospital, in California.

His interest in tuberculosis led him to work from 1934 to 1942 for the Bureau of Tuberculosis, part time. From 1940 to 1944 he was a member of the Board of Directors of the Tuberculosis Association. He was also a member of the Trudeau Society.

In 1940 he became physician for the Territorial Boxing Commission, a post he was to fill effectively for over 20 years. He also became physician for the Oahu Amateur Boxing Association and the Police Activity League. This interest in athletics and boys generally also led him to receive a thirty-year service pin for service on the Troop Committee of Boy Scout Troop 14.

He maintained an active association with Kuakini Hospital, serving an aggregate of six years on its Board of Directors, in the late thirties, the middle forties, and the early fifties. He was Chairman of Kuakini's School of Nursing Commission from 1941 to 1948, and President of its medical staff from 1949 to 1950.

Always interested in music, Barney was a Director of the Honolulu Symphony Society from 1957 to 1960. He was a Fellow of the American College of Chest Physicians. He served as examining physician for Draft Board 4 during World War II.

In 1932 Barney married Setsuko Nishimura, and they had two children, Joyce and Dennis.

The State of Hawaii and we who all knew Barney have lost a dear friend. Not only in his profession did he gain respect but in his association with various community and especially boys' activities was he well known and liked. Up to his unfortunate decedence he took time out to go to a rural boxing program to act as an official. We know he was not well but what a great man he was to "bat" for the youth of this community. I wish to salute Barney in behalf of his friends. Words cannot express my sorrow and truly we have lost a good friend in Barney. To his wife and children we extend our deepest sympathy. May God bless Dr. Barney Iwanaga.

YORIO WAKATAKE, M.D.

County Society Reports

Hawaii

The April meeting of the Hawaii County Medical Society was held at the Hilo Hotel as a dinner meeting on April 27. Guests present were Drs. John Cline, Marie Faus, George Bracher, and Patrick Walsh.

The application of Dr. Henry M. Bockrath for membership was brought before the membership for action. Dr. Henry Yuen moved, Dr. Steuermann seconded, that Dr. Bockrath be accepted into membership of the Hawaii County Medical Society. Motion carried unanimously.

The Big Island Traffic Safety Council asked the assistance of the Hawaii County Medical Society in recommending the use of automobile safety belts for the prevention of injuries in automobile accidents. Dr. Lewis moved that the Society endorse the use of seat belts in all motor vehicles. Dr. Mitchell seconded the motion. The motion was carried unanimously.

The question of charging a fee for filling out Social Security forms for permanent disabilities was next brought up for discussion. Dr. Edward Cushnie's letter from the Hawaii Medical Association was read to the membership. Dr. Henry Yuen moved that the society recommend that a fee of $5.00 be charged to the Social Security Bureau for filling out forms for permanent disabilities. This was seconded by Dr. Lewis and the motion was passed unanimously.

The next on the agenda was a short discussion on the "Honolulu Foundation for Medical Care" (Stockton Plan). Dr. Mitchel moved, seconded by Dr. M. H. Chang, that someone from the Honolulu Foundation be sent to Hilo to explain the plan fully to the membership as suggested in a letter from Dr. George Mills, President of the Honolulu Foundation. The motion was unanimously carried.

Following the business portion of the meeting Dr. John W. Cline, President of the American Cancer Society and Associate Professor of Surgery at Stanford University, spoke on Carcinoma of the Stomach.

* * *

The Hawaii County Medical Society met at the Hilo Hotel May 11, 1961. The Hawaii Medical Service Association acted as host for the evening. Guests present were Mr. J. Veltmann, Mr. Ted Oliphant, Dr. Robert Faus, Mr. Albert Yuen, and Mr. Paul Tallett, of the HMSA office. Other guests present were Drs. Marie Faus, George Bracher, R. Boone, and Patrick Walsh.

Dr. T. Oto and Dr. T. D. Woo, delegates to the Hawaii Medical Association Convention, gave reports to the membership on the recent convention in Honolulu. The written reports were filed with the Secretary.

The representatives of the HMSA, presented the Annual Report of HMSA and the problems confronting the HMSA.

Mr. Oliphant, President of the HMSA, presented a certificate of appreciation to Dr. N. Steuermann, who served as a representative for the Hawaii County Medical Society on the HMSA for the past two years.

Following the business portion of the meeting a movie on the "Tumors of Childhood" was shown.

FRANCIS F. C. WONG, M.D.
Secretary

Honolulu

The April meeting of the Honolulu County Medical Society was called to order Tuesday, April 4, 1961, in Mabel Smyth Auditorium.

The meeting was called to order by President Hartwell at 7:30 P.M. Approximately 85 members were present.

Program:

"Program and Function of WICHE." Speakers: Dr. James Shoemaker, Economist, Bank of Hawaii; Dr. Willard Wilson, University of Hawaii; Dr. Thomas Richert.

"The Management of TB: Its Importance in Overcoming the Obstacles to Eradication." Discussants: Frederick L. Giles, M.D.; Robert Marks, M.D.; Mike Rodsky, M.D. Moderator: Paul Gebauer, M.D.

Dr. Florence J. Chinn was introduced to the membership by Dr. Moore.

Dr. Holmes called the membership's attention to the professional group committee of the Friends of the East-West Center and its function. He stated that he has been asked as a member of that committee to try and interest the Medical Society and other organizations in the community into the workings and operations of the East-West Center.

The Chair announced that the action taken by the membership to request the panel of doctors named by Castle & Cooke to withdraw from the panel has been carried out and that the Medical Society through its Medical Practice Committee has offered to assist Castle & Cooke with any problems they may have.

Relationship of HMSA and HCMS:

The Chair brought out that considerable thought has been given by our Medical Society to the relationship of HMSA and the Society and he would like to open tonight's meeting to a discussion of some of the problems and misunderstandings between the two.

Dr. Robert Katsuki, who requested the floor, stated that what prompted him to appear before the membership this evening was the latest memorandum received by the participating physicians from the Review Committee of HMSA. He pointed out that the initial negotiations for the Federal Employees Medical Plan were undertaken by the Medical Care Plans Committee of the Medical Society; that the present Review Committee of HMSA is not representative of either the Medical Society or the group of participating physicians; that the next negotiating period is between April, now, and June and that the membership will again be faced with effecting contracts with HMSA; and that there already exists a contractual agreement between the Medical Society and HMSA under which individual contracts may be obtained through the Medical Society.

Dr. Katsuki then moved that (1) the Medical Care Plans Committee be designated as the negotiating group for the next contractual period after October 31, 1961, for the Federal Employees Medical Plan and (2) the Honolulu County Medical Society, as per the existing 1952 agreement with HMSA, undertake to execute individual contracts with such of its members as may be willing to serve as participating physicians for the Federal Employees Medical Plan. The motion was seconded by Dr. Reppun.

(Continued on page 598)

In Memoriam - Doctors of Hawaii - XXXIII

This is the thirty-third installment of In Memoriam—Doctors of Hawaii.

Henry L. Bullions

Henry L. Bullions was the son of the Rev. Peter Bullions, D.D., eminent Presbyterian minister and scholar, of Troy, New York.

Young Bullions graduated from Union College at Schenectady, New York, with honors and began the study of medicine in the office of Dr. Blatchford of Troy. After graduating from Albany Medical College in 1853, he served as house surgeon at the Troy Hospital.

In hopes that the climate of the Sandwich Islands would prove beneficial to his health, Dr. Bullions came to Honolulu aboard the "Living Age" in October, 1854. As early as February of the following year, Dr. Bullions and Dr. Seth Porter Ford formed a partnership in the establishment of City Hospital, located at the corner of Kaahumanu and Queen streets. In the first notice of the hospital, appearing February 17, 1855, in the *Polynesian*, they not only solicit the patronage of "strangers visiting the Islands" and residents, but make a strong plea for seamen patients by promising that in the event that the master of a ship is being forced to discharge a seaman because of illness the three months' extra wages required by the U. S. government will be accepted as payment in full of any claims upon the ship or the master. And to further support this bid for such cases, the doctors state in the notice that they are prepared to post bonds with the U. S. consul to prevent a seaman received into the City Hospital from becoming a charge upon the government. By April 14, 1855, the City Hospital notice is run for the first time without Dr. Bullions' name. The hospital did not prove to be a paying proposition, and we are left to wonder if this caused him to withdraw. In any case, by the following October Dr. Bullions is listed as one of the six physicians on the staff of the Honolulu Marine Hospital, established by Dr. George Lathrop.

Taking passage on the "Ocean Telegraph" bound for New York, February 26, 1856, the doctor left the Islands to return to Troy, where he opened an office. However, the climate of New York proved too severe and the doctor returned to Honolulu in November, 1857. The *Advertiser* of November 12, 1857, says: "We would call especial notice to the card of H. L. Bullions, M.D., in another column, to such as may require his professional services. To our old residents it is needless to commend him. Strangers will find him to be not only a skillful physician, but a gentleman, and reasonable in his charges." Following the custom of those days, Dr. Bullions had a drug store in connection with his office, and from time to time he advertised such items as furniture polish and "neat and economical apparatuses for manufacturing soda water, sparkling lemonade and wines, just the thing for family use."

Hawaii's mild climate could not halt the inroads of consumption, and in July, 1858, Dr. Bullions sailed for San Francisco. It was with difficulty and only through the aid of kind friends that he managed to get home where he died at the age of 26.

The *Advertiser,* quoting from an undated article in the Troy, New York, paper, ran the following in their December 23, 1858, edition: "In the death of Henry L. Bullions our city has lost a young man of true goodness of heart and nobility of soul. Possessed of an engaging person, affable manners and a cultivated mind, few young men were more universally esteemed. Had he lived, he would have achieved a high name in the noble profession he espoused and in the cause of science and humanity."

Francis Wong Leong

Francis Wong Leong was born in Honolulu on August 9, 1881. He was the son of Wong Leong and Harriet (Chang Achong) Wong Leong.



DR. LEONG

His early education was received at St. Louis College in Honolulu. He then attended St. Mary's College (now Dayton University) in Dayton, Ohio, where he received his B.S. in 1904. His M.D. degree was granted by St. Louis University, St. Louis, Missouri, in 1908.

On graduating Dr. Wong Leong returned to Honolulu where he was among the first physicians of Chinese ancestry to be licensed to practice medicine.

On August 30, 1905, Dr. Wong Leong and Annie K. Hall were married in Honolulu. They had four children: Francis Edwin, Mary Kalei (Mrs. Henry Duvauchelle), Margaret Thelma (Mrs. William Crozier), and Joseph Wong Leong.

Dr. Wong Leong was acting physician for the Longshoremen's Union. In 1928 he retired because of ill health.

His hobbies included fishing, cultivation of orchids and music.

Dr. Wong Leong died October 10, 1934, in Honolulu at the age of 53.

He was a member of Lunalilo Circle, Court of Lunalilo No. 6600, O.A.F., Phoenix Lodge, Order of Owls, Kamehameha Lodge, Honolulu Chinese Chamber of Commerce, American Medical Association, and the Hawaii Medical Association.

Ferdinand Frederick Hedemann

Ferdinand Frederick Hedemann was born at Hana, Maui, on November 2, 1879. He was the son of Christian J. and Meta (Nissen) Hedemann. His father was consul for Denmark in Hawaii and for many years a leading executive in the Honolulu Iron Works.

He received his early education at Punahou School and Oahu College. In 1899 he entered Harvard Uni-

(Continued on page 598)

OUR NEW PRESIDENT



DR. BURDEN (left) AND FRIENDS

The first Issei (Japanese-born) president of the Hawaii Medical Association spent the first 17 years of his life in his native country, Japan (where his father had a publishing business), sticking up for the United States in arguments with Japanese children, and has devoted a good deal of his time since then to sticking up for the Japanese when they needed it.

J. Alfred Burden received his M.D. from the University of Louisville in 1936, after attending Modesto High School and U.C.L.A. During a three-year stint helping to build Hoover Dam, he met his future wife Helen Brown, a nurse from Minnesota, who married him and convinced him he'd better go back and finish medical school.

After a two-year internship (at Louisville City Hospital and The Queen's Hospital in Honolulu) he went to work on Maui as a plantation physician. Then came the war. He was called to active duty and assigned to Intelligence, where he stayed for four and a half years, during which he rose in rank from First Lieutenant to full Colonel. He never saw a patient during this time. He went through three active campaigns: Guadalcanal, New Georgia and Vella La Vella, and received the Purple Heart, Bronze Star, Silver Star and Legion of Merit. He also received the order of Three White Clouds (which Helen says looks like the top of a tomato can) from Chiang Kai-Shek for his work in the Sino Translation Interrogation Center, which he organized and operated.

After the war he became Medical Director for Maui Pineapple Company, where he has remained until the present.

His hobbies are photography, swimming, stamp collecting, and trying to get that 29 hand. He has been actively associated with the Shrine and with Kiwanis International, being a past President of the Maui club and a past Lieutenant Governor of the Hawaii Division. He has also been an active member of the Hawaii Association of Plantation Physicians, the Academy of General Practice, the Association of Industrial Physicians, and the Maui County Medical Society, of which he is a past President.

The Burdens have two daughters, Betsy, 13, and Barbara, 14. They have residences in Kaluanui and Keawakapu.

105TH ANNUAL MEETING HAWAII MEDICAL ASSOCIATION

HONOLULU
May 4 through May 7

The annual meeting for the one hundred and fifth year of corporate existence of the Hawaii Medical Association was held in Honolulu. The following program was presented:

SCIENTIFIC PROGRAM

Panel Discussions

Trauma
Moderator: Colonel Carl W. Hughes
Panelists: Drs. Scott C. Brainard, Ralph B. Cloward, Vernon K. S. Jim, Rowlin L. Lichter

OB-Gyn Emergencies
Moderator: Dr. Paul F. McCallin
Panelists: Drs. George Goto, H. James Lambert, Jr., Gail G. L. Li, John M. Ohtani

Poisoning
Moderator: Dr. Richard K. B. Ho
Panelists: Drs. Robert T. S. Jim, James L. Mertz, Calvin C. J. Sia, Donald T. Smith, Paul Y. Tamura

Emergencies in the New Born
Moderator: Dr. Wilhelmina Haake
Panelists: Drs. Jeannette Chang, George M. Ewing, William F. Moore, Jr., Allan C. Oglesby

Medico-Surgical Emergencies
Moderator: Dr. Lloyd M. Nyhus
Panelists: Drs. Frank J. Bruce, Robert G. Johnston, Patrick T. Lai, Theodore T. Tomita

Medical Emergencies
Moderator: Dr. A. S. Hartwell
Panelists: Drs. Raymond deHay, S. R. Horio, Elmer C. Johnson, Bernard J. B. Yim

Papers

Chemotherapy in Cancer
Dr. John W. Cline

Unusual Types of Abdominal Pain
Dr. Walter C. Alvarez

Presidential Address
Dr. Edward F. Cushnie

The Lost Art of Diagnosis with Eyes and Ears
Dr. Walter C. Alvarez

Diagnosis and Treatment of Carcinoma of the Stomach
Dr. John W. Cline

SOCIAL PROGRAM

Cocktails and Dinner Dance, Oahu Country Club
Breakfast at Oahu Country Club
Annual Golf Tournament, Oahu Country Club
Picnic for physicians at the home of Dr. Harry L. Arnold, Jr.

MEETINGS

House of Delegates, Mabel L. Smyth Memorial Building
General Membership, Princess Kaiulani Hotel and Mabel L. Smyth Memorial Building
Woman's Auxiliary, Elks Club

DELEGATES

Kauai County:

Burt O. Wade

Alternate
Vernon G. Boido

Hawaii County:

Theodore T. Oto
Timothy D. Woo

Alternates
Nicholas Steuermann
J. A. Mitchel
H. B. Yuen

Honolulu County:

Term ends 1961
Vernon K. S. Jim
Charles S. Judd, Jr.
Ivar J. Larsen
Chew Mung Lum
R. Varion Sloan

Term ends 1962
Morton E. Berk
H. M. Johnson
George H. Mills
Andrew L. Morgan
Walter S. Strode
T. H. Richert
Vernon C. Waite
James T. S. Wong

Term ends 1963
Robert G. Benson
B. W. D. Fong
W. S. Ito
Allan H. H. Leong
A. L. Vasconcellos
F. B. Warshauer

Alternates
C. V. Bergquist
Donald W. Brown
Frank J. Bruce
William W. L. Dang
R. P. C. Ho
Robert T. S. Jim
Patrick Lai
Gail Li
Walter Ozawa
Calvin C. Sia

Maui County:

Clifford F. Moran
A. Y. Wong

REFERENCE COMMITTEES

No. 1—Public Health
George H. Mills
T. T. Oto
A. L. Vasconcellos
Robert T. S. Jim
James T. S. Wong

No. 2—Insurance and Medical Service
M. E. Berk
Bernard W. D. Fong
W. S. Ito
Ivar J. Larsen
Andrew L. Morgan
T. D. Woo

No. 3—Miscellaneous Business
R. Varian Sloan
Vernon K. S. Jim
H. M. Johnson
C. M. Lum
Marion L. Hanlon

No. 4—Parliamentary Affairs
Charles S. Judd, Jr.
T. H. Richert
Water S. Strode
Burt O. Wade
Verne C. Waite

COMMITTEES FOR 1960 AND 1961

STANDING COMMITTEES

Arrangements
Richard D. Moore
James M. Cherry
Albert Ishii
James Marnie
Carl Mason
Randal Nishijima
R. Varian Sloan
L. T. Kashiwa, Maui
T. Kutsunai, Hawaii
Samuel Wallis, Kauai

American Medical Education Foundation
Min Hin Li, *Representative*

Awards
Harry L. Arnold, Jr
Robert Y. Katsuki
H. Q. Pang
M. E. Stevens
C. F. Moran, Maui
B. O. Wade, Kauai
H. B. Yuen, Hawai

Bylaws and Parliamentary
Richard E. Ando
Herbert Y. H. Chinn
Satoru Nishijima
Clarence Y. Sugihara
Rodney T. West
Webster Boyden, Kauai
H. E. Crawford, Hawaii
A. Y. Wong, Maui

Cancer
Grover H. Batten
Harold M. Johnson
Gail G. L. Li
George H. Nip
Walter B. Quisenberry
Irvin L. Tilden
Tokuso Taniguchi, Hawaii
Vernon Boido, Kauai
Guy S. Haywood, Maui

Chronic Illness and Aging
Shoyei Yamauchi
Richard E. Ando, Doctor Education
L. Clagett Beck
Leo Bernstein, Dept. of Health Liaison
Claude V. Caver, Public Relations
John M. Felix
Leabert R. Fernandez, Legislation
David I. Katsuki, City and County Liaison
Ivar J. Larsen, Hospital and Institutional Care
George H. Mills, Indigent Care
Walter B. Quisenberry, Home Care
Kenneth H. Rusch, Mental Health
R. Frederick Shepard, Rehabilitation
Norman R. Sloan, Nursing Care
R. Varian Sloan, Preventive Care
Robert S. Spencer
Grant N. Stemmermann, Research
Bernard Yim
Robert P. Henderson, Hawaii
Peter Kim, Kauai
Edmund A. Tompkins, Maui

Diabetes
Donald W. Brown
George H. Mills
Norman R. Sloan
Louis G. Stuhler
Coolidge S. Wakai
C. S. Brown
L. M. Beers, D.P.
T. W. Kanda, Maui
Peter Kim, Kauai
Kay K. Ota, Hawaii

Emergency Medical Service
Edward W. Boone
Leo Bernstein
Robert Chung
Donald Depp
Robert B. Faus
Raymond H. Hiroshige
Edmund Lee
Fred M. K. Lam, Jr.
P. Howard Liljestrand
Leon E. Mermod
Robert G. Rigler
W. H. Wilkinson
Kenneth K. Fujii, Kauai
Edward B. Underwood, Maui
Richard M. Yamauchi, Hawaii

Chairmen's names appear in **bold** type.

Examining Board for Hansen's Disease
Edward T. Emura

Federal Medical Service
Grover H. Batten
Homer Benson
Ivar J. Larsen
Chew Mung Lum
Carl Mason
Edward T. Matsuoka
Randal Nishijima
O. D. Pinkerton
J. Alfred Burden, Maui
Burt O. Wade, Kauai
R. P. Wipperman, Hawaii

Hawaiian Academy of Science
W. Harold Civin, *Representative*

Health Education
Herbert Y. H. Chinn
Andrew C. Ivy, Jr.
Samuel D. Allison
Gordon Chang
William W. L. Dang
Clifford T. Druecker
Katherine J. Edgar
Merton Mack
Randal A. Nishijima
R. Frederick Shepard
Verne C. Waite
M. L. Hanlon, Maui
Ed B. Helms, Hawaii
Clyde Ishii, Kauai

Heart
Kikuo Kuramoto
Scott C. Brainard
Bernard W. D. Fong
Alfred S. Hartwell
Norman R. Sloan
Marquis E. Stevens
Lester P. K. Yee
Vernon Boido, Kauai
Mun L. Chang, Hawaii
David D. Kliewer, Maui

Hospital Liaison Committee
George H. Mills
L. T. Chun
Ivar J. Larsen
Toru Nishigaya
Roy Tanoue
James T. S. Wong
Bernard J. B. Yim
Vernon G. Boido, Kauai
Frank A. St. Sure, Maui
Sadaichi Kasamoto, Hawaii

Legislative
(* Also members of Honolulu County Legislative Committee)

Leabert R. Fernandez
Ralph M. Beddow
*John Chalmers
Thomas Chang
John W. Devereux
*Thomas P. Frissell
*C. E. Fronk
R. Hadden Gray
A. S. Hartwell
Richard K. C. Lee
P. Howard Liljestrand
Leon E. Mermod
Toru Nishigaya
George D. Oakley
*L. Q. Pang
*B. Allan Richardson
*T. T. Tomita
William H. Wilkinson
*Richard W. You
William Bergin, Hawaii
Samuel M. Haraguchi, Hawaii
R. J. McArthur, Maui
Seiya Ohata, Maui
Patrick M. Cockett, Kauai
Marvin E. Brennecke

Nurses' Liaison
James W. Cherry
Unoji Goto
William S. Ito
Donald A. Jones
George H. Nip
Linus C. Pauling, Jr.
Peter Kim, Kauai
David D. Kliewer, Maui
M. H. Chang, Hawaii

Mental Health
Kenneth Rusch
Clifford T. Druecker
Richard S. Horio
James Mertz
Vernon Boido, Kauai
Nicholas Steuermann, Hawaii
F. H. Tong, Maui
Dorothy Natsui
Robert S. Spencer
Yan T. Wong

Nominating
Harry L. Arnold, Jr.
Edwin Chung-Hoon
George Mills
Toru Nishigaya
O. D. Pinkerton

Personnel
Frederick L. Giles
Harry L. Arnold, Jr.
Edward F. Cushnie
Toru Nishigaya
J. F. Sanders, Maui
G. Y. Tomoguchi, Hawaii
Kenneth K. Fujii, Kauai

Polio
Ichiro Nadamoto
Thomas S. Bennett
M. M. Hasegawa
J. I. Frederick Reppun
P. H. Cockett, Kauai
J. F. Fleming, Maui
Pete T. Okumoto, Hawaii

Public Relations Committee
William H. Stevens
A. S. Hartwell
S. M. Haraguchi, Hawaii
P. Cockett, Kauai
S. Ohata, Maui

Publications Committee
Douglas B. Bell
Toru Nishigaya
William H. Stevens
Paul Y. Tamura
Bernard J. B. Yim

Radium
George W. Henry
Samuel D. Allison
Philip S. Arthur
Hon Chon Chang
Edgar S. Childs
C. C. McCorriston
Richard D. Moore
John Ohtani
Jun-ch'an Wang
Tetsui Watanabe
P. M. Cockett, Kauai
S. M. Haraguchi, Hawaii
Raymond M. Otsuka, Maui

School Health
Masato Hasegawa
Katherine Edgar
Calvin Sia
Varian Sloan

Scientific Program
James M. Cherry
Ralph M. Beddow
Herbert Y. H. Chinn
W. Harold Civin
Grant N. Stemmermann
A. Leslie Vasconcellos
Vernon Boido, Kauai
J. A. Mitchel, Hawaii
C. F. Moran, Maui

ADVISORY COMMITTEES

Board of Management Mabel L. Smyth Bldg.

M. M. Hasegawa
Toru Nishigaya
H. Q. Pang, *Alternate*

Bureau of Crippled Children

(Date indicates expiration of appointment)

John Frazer 1963
Morton E. Berk.....1961
C. M. Burgess.....1962
George M. Ewing.....1961
Robert Look, D.D.S.....1961
Merton Mack.....1963
Ichiro Nadamoto.....1963
L. Q. Pang.....1962
Edward Y. F. Wong, Hawaii.....1962
Ruth Oda, Hawaii, *alt*.....1962
M. A. Brennecke, Kauai.....1962
Clyde Ishii, Kauai, *alt*.....1962
W. B. Patterson, Maui.....1963
W. P. Pfaeltzer, Maui, *alt*.....1963
Edwin D. Willett, Lanai.....1962
Paul G. Stevens, Molokai.....1962

Bureau of Tuberculosis

Nobuyuki Nakasone
L. Clagett Beck
George W. Henry
John T. Kometani
Robert H. Marks
Frances Won
Peter Kim, Kauai
Edmund A. Tompkins, Maui
Francis F. C. Wong, Hawaii

Bureau of Maternal and Child Health

(* Members of Infant Mortality Sub-committee)

George Goto, *Chairman*.....1961
Herbert E. Bowles.....1961
Clifford K. W. Chock.....1962
*L. T. Chun.....1962
Charlotte Curtis 1963
*Lt. Col. J. P. Fairchild.....1962
John M. Felix.....1961
*Ross Hagino.....1963
John Handley 1963
Robert T. S. Jim.....1961
*John T. Kometani.....1961
James Lambert.....1963
*William F. Moore.....1961
Arno J. Mundt.....1962
*Frances F. Nakamura.....1962
Satoru Nishijima.....1961
Joseph T. Nishimoto.....1962
*Allan C. Oglesby, *Chairman*, Sub-committee 1962
Thomas K. Oshiro.....1962
John I. F. Reppun.....1961
Albert L. Shimamura.....1963
*Grant N. Stemmermann.....1962
Philip Watt.....1963
James Wong 1963
Jack S. Woodruff.....1961
Col. Ed A. Zimmermann.....1962
M. A. Brennecke, Kauai.....1962
Clyde Ishii, Kauai, *alt*.....1962
Edward Y. F. Wong, Hawaii.....1962
Ruth Oda, Hawaii, *alt*.....1962
Paul G. Stevens, Molokai.....1962
Edwin D. Willett, Lanai.....1962
William B. Patterson, Maui.....1963
William P. Pfaeltzer, Maui, *alt*. 1963
(n.b. This is a standing committee per revised bylaws)

Bureau of Venereal Disease

John Chalmers
Samuel D. Allison
Edward T. Emura
Charlotte M. Florine
Koon Sun Fong
Linus S. Pauling, Jr.
J. I. Frederick Reppun
Norman R. Sloan
Vernon Boido, Kauai
M. H. Chang, Hawaii
F. H. Tong, Maui

Bureau of Workmen's Compensation

Andrew L. Morgan
Samuel D. Allison
Philip S. Arthur
Robert F. Bailey
Thomas S. Bennett
Scott C. Brainard
Donald Depp
John W. Devereux
Ivar J. Larsen
Ichiro Nadamoto
George H. Nip
B. Allan Richardson
R. Varian Sloan
Roy T. Tanoue
Wayne W. Wong
K. Izumi, Maui
Harold Lewis, Hawaii
Burt O. Wade, Kauai

Women's Auxiliary to the Hawaii Medical Association

Homer Benson
Frederick Giles
H. Q. Pang
W. E. Iaconetti, Maui
Clyde Ishii, Kauai
H. Okada, Hawaii

AD HOC COMMITTEES

Association of Professions

A. Leslie Vasconcellos
W. Harold Civin
R. T. Kainuma
M. H. Lichter
R. T. West
Robert Miyamoto, Hawaii
K. Fujii, Kauai
J. E. Andrews, Maui

Hawaii Medical Practice Act Review

B. Allan Richardson
Samuel D. Allison
Leo Bernstein
Thomas F. Fujiwara
Kikuo Kuramoto
Richard K. C. Lee
Irvin L. Tilden
Raymond C. Yap
Samuel Yee
S. Mizuire, Hawaii
William W. Goodhue, Kauai
E. T. Shimokawa, Maui

Physicians' Aid Study

Frederick L. Giles
Herbert Y. H. Chinn
Andrew L. Morgan
H. Q. Pang
Thomas Richert
Webster Boyden, Kauai
Ted Oto, Hawaii
F. A. St. Sure, Maui

SPECIAL APPOINTMENTS

The National Foundation's Health Scholarship Committee—C. M. Burgess
Inter-Professional Coordinating—Leabert R. Fernandez, Theodore T. Tomita

PROCEEDINGS OF THE HOUSE OF DELEGATES

of the Hawaii Medical Association
105th Annual Meeting

The first session of the House of Delegates of the Hawaii Medical Association was called to order by the President, Dr. Edward F. Cushnie, at 1:15 P.M., May 4, 1961, in the Mabel L. Smyth Memorial Building Auditorium, Honolulu.

Present: Drs. Edward F. Cushnie, J. A. Burden, Toru Nishigaya, A. S. Hartwell, S. Ohata, T. T. Oto, Timothy D. Woo, Robert G. Benson, Morton E. Berk, Bernard W. D. Fong, William S. Ito, Vernon K. S. Jim, H. M. Johnson, Charles S. Judd, Jr., Ivar J. Larsen, Chew Mung Lum, George H. Mills, Andrew L. Morgan, Walter S. Strode, Thomas H. Richert, A. L. Vasconcellos, Vernon C. Waite, James T. S. Wong, Robert G. Benson, and Burt O. Wade. In addition

Dr. Hartwell appointed the following: Donald W. Brown to replace Allan H. H. Leong, and Robert T. S. Jim, to replace Dr. Frederick B. Warshauer. Dr. Ohata appointed Marion L. Hanlon, to replace Clifford F. Moran, and Joseph E. Andrews, to replace A. Y. Wong.

The delegates were certified and seated by the Secretary, Dr. Rodney T. West, who pronounced the roll call in order.

Dr. Cushnie welcomed the delegates and thanked them for giving up their time to guide the Association in its annual policy-setting deliberations.

The minutes of the May 12, 1960, meeting were approved as published.

The reference committee appointments were made and the referrals made.

Dr. George H. Mills was asked to give a progress report on the Honolulu Foundation for Medical Care. Dr. Richard K. C. Lee advised that various members of his staff were present and offered their assistance in the reference committee deliberations. Dr. Cushnie asked if there were any objections to this offer, and there being none the reference committees were assigned meeting places and the House of Delegates recessed at 1:30 P.M.

The second session of the House of Delegates was called to order on Friday, May 5, 1961. The Secretary declared that there was a quorum and the meeting was called to order at 1:15 P.M., and the President asked for the reference committee reports.

PUBLIC HEALTH REFERENCE COMMITTEE

Mr. President and members of the House of Delegates:

Your Reference Committee on Public Health gave careful consideration to the matters referred to it and makes the following report.

CANCER COMMITTEE

One committee meeting was held in the Kinau Hale Conference Room on March 29, 1961, at 8:00 A.M. in conjunction with one of the regular Monday morning Cancer Commission meetings.

Members discussed the progress made by the Cancer Commission in setting up the Hawaii Tumor Registry. They were advised of the difficulties being encountered in getting the Cancer Quackery bill enacted into law. The Committee went on record favoring the continuation of the present relationship of the Cancer Commission to the Cancer Committee whereby it is directly responsible to this committee, and further recommended that the two entities be continued on the same basis.

The Cancer Commission's annual report to the Committee covered the following: Commission met on a biweekly basis to handle the many details relating to the establishment and operation of the Hawaii Tumor Registry and the participating hospitals. All hospitals have indicated an interest in participating. Registries are already functioning in all the hospitals on Kauai, in Central Maui and Kula Hospitals on Maui, Hilo Memorial Hospital on Hawaii, and at Queen's, Kuakini, Kapiolani, St. Francis, Tripler, and Wahiawa General Hospitals on Oahu. During the year the regular staff members of the Registry visited hospitals in all the counties and some of the Commission members visited Kauai, and Maui. Plans are under way to bring in those hospitals not yet formally participating in the Central Registry. At least one member of the Commission will go to Lanai, Molokai, and Hawaii in the immediate future.

Consultations with the Attorney General's office, State of Hawaii, revealed that under the Cancer Control Act physicians will not be unlawfully revealing privileged information by participating with the hospitals and Central Tumor Registry.

The members of the Commission have been Drs. Grover Batten, chairman, and Shoyei Yamauchi (from the HMA), W. H. Civin and I. L. Tilden (from the American Cancer Society), and W. B. Quisenberry and N. R. Sloan (from the Department of Health).

GROVER H. BATTEN, M.D.

Cancer Committee

Your reference committee recommends that the President of the Hawaii Medical Association continue to appoint the chairman of the Cancer Commission and that the tenure of his office be specified, and he may succeed himself as chairman.

Your reference committee also recommends that the two physician representatives from Hawaii Medical Association have staggered periods of appointments to the Commission so that at no time will both Hawaii Medical Association representatives to the Commission be removed from the Commission in the same year. This will allow for continuity. It also recommends that the present Hawaii Medical Association representatives continue for at least a minimum of two more years, and that in the future a Hawaii Medical Association representative should be appointed for not less than three years.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

EXAMINING BOARD FOR HANSEN'S DISEASE

No cases were presented to The Examining Board for Hansen's Disease during the past year. The Committee has no suggestions or recommendations.

EDWARD T. EMURA, M.D.

Examining Board for Hansen's Disease

Your reference committee recommends the acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

DIABETES COMMITTEE

The Diabetes Committee of the Hawaii Medical Association met on numerous occasions during the past year. We selected, as our main goal, education of the public as regards the need for early diagnosis and dangers of this disease. Our campaign was centered entirely around Diabetes Week, which was held in November. In order to obtain publicity we used the services of Mr. Hugh Lytle extensively. The Clinitron machine furnished by the Board of Health for our use was set up at strategic locations in town. A large number of patients were screened for diabetes and a number of new cases were detected. The primary function of this screening, however, was one of publicity since, of course, only a very minute fraction of the total population of our State was actually tested.

DONALD W. BROWN, M.D.

Diabetes Committee

Your reference committee recommends the acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

HEALTH EDUCATION COMMITTEE

The main effort of our committee in 1960 was to prepare ourselves to produce regular monthly television programs using the new process called video-taping. The committee voted to obtain three of these tapes. Realizing that this schedule would be a busy one, the committee was organized into two sections with co-chairmen, Drs. Herbert Chinn and A. C. Ivy. Preparation of the first three programs started in late November. Two programs on surgery of the eye were taped as well as one on skin conditions. The committee has been very enthusiastic so far with this method of producing TV programs for the following reasons:

(1) The participants seem to be more relaxed knowing that the program can be redone if the first taping is not satisfactory.

(2) Programs can be shown more frequently and at more ideal hours.
(3) By having the three tapes, exceptional programs can be saved to be reshown at a later date or perhaps on other islands when they do have their own TV stations. We have had a request from a group in Texas to show a tape in their state.
(4) Possible usage in the future for enclosed TV circuits at the University of Hawaii or in the local public school system.

A program on plastic surgery has been taped and is ready for showing. Two programs are presently being prepared on the subjects: (1) What's new in relief of hearing problems; (2) The general practitioner. Three films and a possible live program to be shown by HMSA on TV are being reviewed by our committee.

Thus far, the committee is very satisfied with the new method of pre-taping our programs and will continue to do so during the next fiscal year.

A. C. Ivy, Jr., M.D.
Herbert Y. H. Chinn, M.D.

Health Education Committee

Your reference committee recommends adoption of this report and further suggests that continual adequate financial support be given this committee for the presentation of its program.

ACTION:

The chairman moved adoption of this portion of the report. The report was adopted.

HEART COMMITTEE

The Heart Committee has not met since October 17, 1959, and has no recommendations to make.

Kikuo Kuramoto, M.D.

Heart Committee

Your reference committee recommends the acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

MENTAL HEALTH COMMITTEE

I have no report to render inasmuch as there were no meetings of the committee on mental health this year.

Kenneth H. Rusch, M.D.

Mental Health Committee

Your reference committee recommends the acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

POLIO COMMITTEE

This committee had only one meeting, on February 14, 1961, which was called to discuss the new oral vaccines and what stand to take on legislation which might be introduced during the coming session. An unfortunate newspaper release followed this meeting which seemed to have come from someone present at the meeting. In addition to the regular members, Drs. Bernstein, Enright, and Quisenberry were present. Everyone present denied discussing the subject of the meeting with the press.

After a lengthy discussion on the advantages of immunizing an entire community at one time, the committee decided to recommend that when oral vaccine becomes available and proper standards of medical supervision are set up locally, immunization be given to all children in Hawaii between the ages of one month and 18 years and further that the Legislature budget sufficient funds for the project. In addition, the committee recommended that each county individually work out a schedule for the immunization program.

Ichiro Nadamoto, M.D.

Polio Committee

Your reference committee recommends that all state society committees and committee members should always exercise caution in releasing any information to the press and that the public relations staff be utilized.

The committee agrees in principle to the recommendation that when the time is right the entire community be educated to the idea that oral vaccine be given in a two-week period. However, before this is done the physicians should agree on the specific time this program is to run and specifically who will be included.

We also recommend that vaccine obtained with funds budgeted by the Legislature be used only for the indigent and medically indigent.

ACTION:

The chairman moved adoption of this portion of the report. The report was adopted.

SCHOOL HEALTH COMMITTEE

This newly formed committee met once, on April 4, to discuss the different facets of the school health program. Among the items on the agenda were the proposed revision of Form 14, the timing of the school examinations, use of the audiometer, the hearing program, T&A's, and the school lunch program.

The work of this committee covers an area which needs development but it will take some time. It is recommended that in the future informed resource people be called in to advise the doctors on the different school health programs.

Masato Hasegawa, M.D.

School Health Committee

Your reference committee recommends the acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

RADIUM COMMITTEE

The following is the report of the Radium Advisory Committee for the year of 1960-61. The Committee proposes the following recommendations to the House of Delegates for their approval:

One person or one department shall be responsible for the radium in the hospital. His duties shall be as follows:

General Recommendations for the Use of Radium in the Hospital

1. Set up safety regulations for the protection of personnel and patients.
2. Keep record of its use; therefore he must be notified by the doctor, or his assistant, whenever radium is to be used.
3. Supervise and regulate the safe storage of the radium before and after application.
4. Keep the monitoring instruments in good working order.
5. Keep personnel exposure record.

Necessary equipment and protection aids are:

1. Protective—Lead L, lead bricks. Long handled forceps.
2. Monitoring—Gamma-survey meter. Film badges or pencil dosimeters.
3. Transport—sturdy cart to convey radium and protective equipment.

Operative precautions are as follows:

1. No pregnant woman is to be assigned to work on any case in which radium is being used. She may be assigned before or after the treatment.

2. The radium must be placed in a lead (2 cm. wall) container immediately before and after the application.
3. Applicators should be prepared as far as possible in the radium room, and manipulation or changes in the OR should be avoided. If required see #2 under "Specific Rules."
4. Nurses and other personnel attending the patient must remain as far as possible from that part of the patient receiving the radium treatment. In other words—KEEP DISTANCE.
5. If radium must be handled, it should be done only with long-handled tongs or forceps, and never with the fingers. No radium source or capsule may ever be touched with the fingers.
6. If at any time the applicator in the patient is accidentally displaced, or becomes loose, the attending doctor must be notified immediately. Radium expelled from the patient is to be placed in a lead container immediately.
7. Dressings, bedclothes, and items of clothing must first be checked for possible loose radium before they are discarded. However, the danger of contamination is nil because the containers are sealed.
8. Film badges or pocket dosimeters must be available or supplied to each person working close to the patient.

In operating room, special precautions should be taken:

1. If at any time the radium applicator is loaded or reloaded in the OR, the room must be monitored for possible loose radium before anything is discarded or removed from the room. The manipulation of the radium shall be done behind a lead shield. This gives a good deal of protection, but is not within the safe levels unless the time is short. The lead screens can give a false sense of security.
2. In order to cut down on exposure to the personnel, the patient with the radium must be evacuated as soon as possible.

In the recovery room,

1. The distance between beds must be at least 6 feet.
2. Personnel attending patients with 100 mg. radium are allowed 35 minutes, depending on the distance. Details in each case will vary with the circumstance, and hospital rules will take this into account.
3. No visitors allowed in recovery room to see patient.

In the patient's room,

1. The distance from other beds must be at least 9 feet.
2. Visitors are allowed in room but must remain at least 6 feet from patient.
3. A safe distance to keep a bed patient with 100 mg. radium from the nurses' station is 20 feet (1.5 milliroentgens/hr.)

It is desirable that consultation with a radiologist be obtained in setting up the regulations in each hospital. The Hawaii Medical Association Radium Advisory Committee will help arrange such if requested.

The Radium Advisory Committee unanimously recommends to the House of Delegates the adoption of the above.

GEORGE W. HENRY, M.D.

Radium Committee

Your reference committee recommends adoption of the minimum standards for handling radium set down by the Radium Advisory Committee with the following amendments:

In the third paragraph, "Operative Precautions are as follows," last line under 3, correct to read: "If required, see 1. below under "In operating room." Also correct 7. under "Operative precautions" to read:

> "Dressings, bedclothes, and items of clothing must first be checked for possible loose radium before they are discarded. Even though the danger of contamination is nil because the containers are sealed, such checks are necessary because of the great risk involved."

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

ADVISORY COMMITTEE TO THE BUREAU OF CRIPPLED CHILDREN

One meeting was held on January 6, 1961, at the Mabel Smyth Building. The following is the report of this Committee:

(1) Dr. Connor reported that Dr. C. Walton Lillehei and Dr. Ray Anderson made a survey of the facilities for open heart surgery in October, 1960. The consultants felt that The Queen's Hospital Team was ready to proceed while the St. Francis Hospital Team is getting ready. The St. Francis Hospital Team has not indicated to the Bureau of Crippled Children that they are ready to go ahead. Dr. Lillehei also added that two teams in Hawaii were not unusual. However, the teams should work together and have conferences and share their reports.

(2) The U. S. Children's Bureau has indicated that they do not plan to underwrite any more new cardiac centers anywhere in the United States. Federal funds are available for hospital and surgical fees for children sent to the mainland. The Bureau of Crippled Children still sends children to the mainland for open heart surgery after approval has been given by the Cardiac Advisory Committee.

(3) It was recommended, with one dissenting vote, that the Council of the Hawaii Medical Association act on a fee schedule for Bureau of Crippled Children cases for all procedures based on 60 per cent of the Honolulu County Medical Society's Relative Value Fee Schedule as listed or amended. Dr. Berk has already submitted a minority report to you and to the Honolulu County Medical Society.

(4) It was recommended that the Chief, Bureau of Crippled Children, meet with whatever committee the Dental Society designates to discuss the dental fee schedule. The Chief will inform them of the action the Medical Association has taken in regard to a percentage of the Medical Society's fee schedule in the hope of arriving at something similar with the Dental Society.

JOHN P. FRAZER, M.D.

Advisory Committee to the Bureau of Crippled Children

Your reference committee recommends that Dr. Berk's minority report be accepted and that further studies be done in regard to the problem of fees before a fee schedule is accepted for the cases from the Bureau of Crippled Children.

The committee also recommends that no action be taken to discuss fee schedules with the Dental Society.

ACTION:

The chairman moved adoption of this portion of the report.

Dr. Cushnie asked for discussion on this subject. Dr. Richert asked if adoption of the report would mean that the minority report would be adopted. Dr. Hanlon said that the doctors on Maui had no contact with the minority report. Dr. West advised that the minority report had been adopted by the Council at which time two Maui representatives were present. Dr. Berk elaborated on the thinking behind his report. He stressed the importance of uniformity in fee schedules and said that if an individual doctor wants to take care of BBC cases for a reduced fee or for nothing, that is his prerogative, but the Medical Association should not go on record as accepting a reduced fee schedule.

The report was adopted.

ADVISORY COMMITTEE TO THE BUREAU OF MATERNAL AND CHILD HEALTH

The objectives of the Committee are to serve as an advisory committee to the Bureau of Maternal and Child Health of the State Department of Health; and also to function as a maternal and infant mortality study committee. The purpose of the latter might be defined as a committee to study

maternal and infant deaths in order that (1) avoidable factors in maternal and infant deaths may be reduced or eliminated and (2) better maternal and infant care may be assured through improvement in teaching and practice.

Major activities of the Committee for 1960 were as follows:

1. The Chairman summarized studies of ten maternal deaths occurring in 1960. (Two more 1960 deaths occurred so late in the year that they have not been discussed and classified.) Four of the ten were classified as directly obstetrical and preventable.

2. Dr. Oglesby, Chairman of the Infant Mortality Section, summarized the infant death case studies for 1960. Seventeen infant deaths were studied of which ten were classified as preventable. Four were unclassifiable as to preventability because of lack of sufficient data. Nine cases which were studied by the Committee were prepared for publication in the HAWAII MEDICAL JOURNAL, and published.

3. The Chairman reported that several legislators are interested in introducing a bill into the legislature which would protect the maternal and infant mortality case study records from subpoena. Educational work of the Committee has been hampered by concern of physicians over this possibility. Several states now have legislation which prohibits such study records from being admitted as evidence.

4. Mr. Charles Bennett of the Bureau of Health Statistics of the Department of Health reported that a revision of the Vital Statistics Act, Part I, Chapter 57, Revised Laws of Hawaii, is being proposed to the Legislature. In particular, he asked the Committee members their opinions as to revision of the method of fetal death reporting. The Committee's unanimous opinion was that reporting of all fetal deaths should continue, but that a simplified report form be developed for those below the period of viability.

5. Several Committee members attended two meetings on neighbor islands with County Medical Societies to present case studies. Members (who travel at their own expense) find these meetings interesting, and the hospitality enjoyable. The availability of consultation through the Bureau of Maternal and Child Health for indigent and medically indigent, maternity and newborn cases is emphasized at every opportunity. There have been more requests for such this year.

The Committee has no special recommendations for the House of Delegates.

GEORGE GOTO, M.D.

Advisory Committee to the Bureau of Maternal and Child Health

Your reference committee recommends solid support of the bill which would protect the maternal and infant mortality case study records from being subpoenaed.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

ADVISORY COMMITTEE TO THE BUREAU OF TUBERCULOSIS

This committee met only once, on August 3, 1960. At that meeting the Bureau's new regulations were discussed as well as the "6 mm maximum" criteria specified in these regulations. Inasmuch as the new regulations had been adopted, the matter of changing the criteria was dropped. The committee authorized the Bureau to send a brochure to those physicians treating patients with tuberculosis and remind the private physicians that they are encouraged to call the sanatoria for consultation. The committee recommended that space be provided in the HAWAII MEDICAL JOURNAL for a regular Department of Health column.

The treatment of ambulatory patients on Oahu was discussed and this was referred to the Honolulu County Board of Governors.

Regarding the school health program, the committee felt that it would be a good idea to give all children tuberculin tests when they receive their required examinations.

NOBUYUKI NAKASONE, M.D.

Advisory Committee to the Bureau of Tuberculosis

Your reference committee recommends that physicians be made cognizant of the consultation facilities which are provided by the various sanatoria.

It also recommends that pre-school children and children with a known negative tuberculin test be given this test with their annual school examinations.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

ADVISORY COMMITTEE TO THE BUREAU OF VENEREAL DISEASE

The Committee met on November 23, 1960, to discuss the proposed transfer of the Venereal Disease Clinic to the outpatient departments of various hospitals throughout the state. Subsequent investigations indicated that several hospitals were interested, but in view of a later recommendation that a Federal survey had been requested (more will follow on this), it was felt that the Venereal Disease Clinic should be maintained as it is at present until the survey has been made and recommendations studied.

In connection with the above, Dr. Frank Glaser attended a meeting in Dallas, Texas, in which it was reported that despite the amazing increase in venereal disease throughout the country, the extremely low rate in Hawaii was somewhat enigmatic. It was suggested that an epidemiologist in the employ of the Federal Government be allowed to come to Hawaii for a period of six months to a year to determine: "(1) if we have eradicated venereal disease, or, (2) eradicated the control program." After considerable discussion, it was moved, seconded, and unanimously passed that we endorse the investigation on the basis that it not be done with a firm commitment for one year, and that we make this recommendation to the council.

The recommendation that the premarital examination for venereal disease be discontinued was voted down.

The Committee recommended that the Department of Health liberalize wording of the premarital health certificate. The Committee further supported the recommendations of the State Department of Health for changes for the various complement fixation tests for syphilis.

A second meeting of the Committee was held on March 15, 1961, to hear a report from Dr. Glaser on the Dallas meeting. The Committee went on record as approving the transfer of the Venereal Disease Clinic from the Bureau of Adult Health to the Bureau of Epidemiology of the Health Department.

The committee wishes to express its appreciation to Drs. Lee, Sloan, Enright, Glaser, and Quisenberry for their cooperation and attendance at the meetings.

JOHN F. CHALMERS, M.D.

Advisory Committee to the Bureau of Venereal Disease

Your reference committee believes that premarital examination for venereal disease should be continued, especially in view of the fact that there is a definite increase in venereal disease on the mainland.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

The chairman moved adoption of the report as a whole. It was adopted.

INSURANCE AND MEDICAL SERVICE REFERENCE COMMITTEE

Mr. President and members of the House of Delegates:

Your Reference Committee on Insurance and Medical Service gave careful consideration to the matters referred to it and makes the following report:

CHRONIC ILLNESS AND AGING COMMITTEE

Principal Activies: 1. Preparation for the White House Conference on Aging, January, 1961. 2. Establishment of a pilot study project at The Queen's Hospital: Rehabilitation of the chronically ill in a general hospital and nursing home. 3. High cost of hospital care.—Hospital Committee.

White House Conference on Aging, 1961—Pre-Conference Activities: The Committee's activities were chiefly concerned with the preparation for the WHCA. Anticipating an active year, the membership was enlarged, sub-committee chairmen assigned in the various categories of interest areas pertaining to possible future activities of the committee.

On July 18 and July 25, state recommendations submitted by the Governor's Interim Commission on Aging were reviewed item by item. The Sections on Health and Medical Care and Financing of Medical Care were particularly carefully scrutinized, additions and deletions were made, and endorsed. Dr. Harry Arnold, Jr., and I served as consultants for the final State Recommendations.

Drs. Harry Arnold, Jr., and Richard P. Moore participated in a forum on the question of financing medical care. Both presented doctors' viewpoints clearly and effectively. Our thanks to them for performing this difficult task so well.

The presence of a field representative of A.M.A., Mr. Dalbec, at a time when the appointed delegates to the WHCA, 1961, were having orientation programs greatly enhanced organized medicine's interest. Mr. Dalbec was asked numerous questions concerning organized medicine. Only an informed representative, such as he, could supply many of the acceptable answers. This Committee should look forward to more help from Mr. Dalbec and his A.M.A. associates.

At the WHCA, 1961, Dr. Leo Bernstein officially represented the Governor and was asked to tell Hawaii's story at a sectional meeting. Dr. Norman Sloan, a member of the 150-member National Advisory Committee for the Conference, attended as a delegate, assigned to Social Services. I was assigned to the Health and Medical Care Section and acted as a liaison man for Hawaii's physicians at the A.M.A. breakfast meetings.

A great concern for various problems affecting the aged was expressed at the WHCA, 1961, and at the preparatory Hawaii State Conference on Aging (May, 1960). The WHCA formulated general policy statements largely based on state recommendations. State conferences defined the problem as it exists in individual States.

The general policy statements of WHCA, 1961, with a few exceptions make a sound guide to fill gaps, correct inadequacies, and develop fuller and meaningful programs. The Governor's State Conference on Aging has clarified local needs and defined priorities of action.

Immediate Actions Needed in Hawaii: The first need is the creation of a permanent Commission on Aging for Hawaii. Bills have been introduced into both sections of the State Legislature for action and are strongly backed by our Legislative Committee. All physicians in the State are urged to help get this bill enacted.

The passage of the Kerr-Mills bill by the 86th Congress was a triumph for organized medicine and an answer to the cry of help for the needy aged. Dr. Harry Arnold, Jr., attended the special meeting of A.M.A. called on November 27, 1960, to discuss this law. The proper implementation of the law will give adequate medical care to those who need help. Physicians of this State should support the proper implementation of this law.

Nationally, socialized medicine is again knocking at the physicians' door; this time by way of the "aging problem." Mr. Kennedy has appointed Wilbur J. Cohen, the University of Michigan social welfare professor, to direct the legislative section of HEW. Mr. Cohen is a protege of Isadore Falk, a proponent of socialized medicine. Mr. Cohen is said to have rigged the WHCA, 1961, and influenced the WHCA to recommend the financing of medical care through the Social Security approach. (Shearon Report)

Prevention of Fragmentation of Health Services: Leadership in developing programs for health and medical care should come from physicians and health oriented agencies, both official and voluntary. Otherwise, those less qualified by training and experience will take over, especially in situations where political considerations prevail. Some of the recent events should grimly remind us of what could and might happen.

The responsibility of implementation of the Kerr-Mills law in Hawaii is now in the lap of State Department of Social Services. This law was created for the specific purpose of helping the medically needy. Hawaii's physicians have a tremendous interest in the proper implementation of this law. But an offer from this Committee and President Cushnie of a strong advisory group to the Department has been ignored.

The WHCA, 1961, policy statement reads: "A major obstacle to continuity of care and coordination of services lies in the fractionation of health services away from agencies concerned primarily with health matters." Recommendation reads "Federal, State and local programs in the field of health and medical care be administered by medically oriented agencies."

Rehabilitation of the Chronically Ill in a General Hospital and Nursing Home—A Pilot Study: Meetings were held with representatives of the Division of Vocational Rehabilitation, Mr. Kuniji Sagara, and Miss Rosemary Hayes, who presented the working plan for the project and invited the HMA to participate in the program. After the August 16 approval by the Council with provision to keep it under the control of physicians, a panel of physicians, with Dr. Nishigaya as chairman, was appointed by Dr. Cushnie. This Committee was instructed to supervise the details so that they will be carried out in accordance with the precepts of the medical profession. The project was set up at The Queen's Hospital and is supported by Federal grant. The first report of this demonstration study project is now available. Dr. Nishigaya requests a fuller cooperation from the medical profession. The panel requests more and early referrals in the course of disability so that more effective total rehabilitation programs would be carried out.

High Cost of Hospital Care—Hospital Committee: The spiralling cost of hospital care has been discussed particularly from the standpoint of financing such costs and possible development of new and more economical institutional and home-care programs. The Committee favors developing Progressive Patient Care Programs in general hospitals integrated with nursing home and home-care programs. HMSA representatives have indicated their willingness to support such a program and have urged our Committee to help initiate such programs.

Joint meetings with hospital administrators have indicated that further discussion must be held with members of hospital boards, preferably the chairmen. The problem seems so large that a special hospital committee, with George Mills as chairman, has been appointed by President Cushnie to look into this matter. The day may come when "the right person, gets the right care, at the right place at the right time at the right cost" (Edwin Crosby, M.D., President of American Hospital Association).

Recommendations: To properly implement the above and other programs, still to be developed, our Committee recommends:

1. That the Hawaii Medical Association continue to strongly support legislation to establish a permanent Commission on Aging in Hawaii.

2. That when such a Commission is established, Hawaii's physicians participate actively in the affairs of the Commission so that health matters affecting the people of Hawaii will not be without medically oriented considerations and implementations.

3. Encourage health institutions in Hawaii to develop their facilities and services so that the right people get the right care at the right place at the right time at the right cost.

4. Encourage health insurance carriers in Hawaii to develop adequate medical care plans for people including those over 65 years by proper implementation of the third recommendation.

5. Continued support of the Kerr-Mills law by helping to adequately implement it in Hawaii.

6. Continued opposition to any and all attempts, however camouflaged, by the Federal Government to introduce legislation to socialize medicine, to wit, opposition to the Social Security approach of financing medical care for the aged.

7. Take immediate steps to prevent fractionation of health services away from agencies concerned primarily with health matters, by placing State and local programs in the field of health and medical care in the administration of medically oriented agencies. This will insure continuity of care and prevent duplication of services and waste of taxpayers' money.

SHOYEI YAMAUCHI, M.D.

Chronic Illness and Aging Committee

Your reference committee recommends acceptance of this report with emphasis on #6, regarding continued opposition to any and all attempts to socialize medicine; to wit, opposition to the Social Security approach of financing medical care for the aged.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

FEDERAL MEDICAL SERVICES COMMITTEE

The Federal Medical Services Commitee met several times during the year. As usual, the most difficult cases to adjudicate were those pertaining to obstetrics. Because of problems associated with the OB schedule and the trimester breakdown the matter of publishing the fee schedule was discussed by the committee but no final conclusion has been reached.

The only other material problem associated with claims and other services rendered was that an insufficient amount of information was given to the committee by the responsible physician.

General Floyd Wergeland and Col. Gray of the Office of Dependents Medical Care met with the committee. They presented a brief history of Medicare and expressed satisfaction with the program as it is operated in Hawaii.

The new Medicare contract must be negotiated prior to June 30, 1961. It is suggested that no changes be made at that time and that the present contract be renewed for one year.

There were no problems relating to the Veteran's Administration contract which is due for renewal for the period July 1, 1961 to June 30, 1961.

The Medical Care program for the Federal Civil Service employees was not considered by this committee during the past year because this was taken from the prior committee of 1959 and 1960 and handled by the Medical Care Plans Committee of the Honolulu County Medical Society.

The chairman would like to take this opportunity to thank all the members of the Federal Medical Services committee for the help and cooperation they have given him.

GROVER H. BATTEN, M.D.

Federal Medical Services Committee

Your reference committee suggests no changes be made in the present Medicare contract for one year. The Chairman of this Committee, Grover Batten, M.D., recommended that although the fee schedule for Medicare was substandard in a few areas, on the whole it is an acceptable fee schedule and we therefore should continue on the same basis for the next contract year. The correction should be made in the report relating to dates; viz., for the period July 1, 1961, to June 30, 1962, instead of "1961."

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

HAWAII MEDICAL PRACTICE ACT REVIEW COMMITTEE

Revision of the Medical Practice Act was recommended as mandated by the membership. At the time that this report was submitted, the revised Medical Practice Act was being acted on in the present legislature.

B. ALLEN RICHARDSON, M.D.

Hawaii Medical Practice Act Review Committee

Your reference committee recommends the following:

That a Hawaii Medical Practice Act Study Committee be continued for at least two years.

Furthermore, the deliberations and decisions made by this Committee should be forwarded to the State Medical Association's Legislative Committee for further action.

During this time the following points should be explored:

(a) The Committee's action in regard to licensing graduates from foreign medical schools.

(b) The definition of "medical practice" in the State of Hawaii.

(c) Possible licensing or registering people covered by No. 2, i.e., psychologists, nutritionists, physical therapists, etc.

Furthermore, we believe it is urgent that the members of the State Medical Association be made aware of the present revised Medical Practice Act as recommended by the current study committee and that the revision as presented to the Legislature be incorporated in these proceedings.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

HOSPITAL COMMITTEE

The Hospital Committee of the Hawaii Medical Association is a new committee formed to study the relationship between the doctor and hospital. The first meeting was held on April 3, 1961. This meeting was called in order that the members of the committee could become acquainted with each other and some of the problems to be considered were outlined.

These problems are:

1. Hospital costs and what we can do to bring them down;
2. Problem of the aged and adequate hospitalization for them;
3. Prepaid hospital insurance;
4. The indigent and his relationship to the hospital and physician;
5. The importance of the physician in the training program in the hospital: what this program means to the community;
6. Progressive patient care;
7. The type of hospitals needed in the community in the future.

At the meeting in May, Mr. Will Henderson, President-elect of the Hawaii Hospital Association, will be asked to give his views on progressive hospital care in Hawaii.

GEORGE H. MILLS, M.D.

Hospital Committee

Your reference committee recommends that this report be accepted.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

ASSOCIATION OF PROFESSIONS STUDY COMMITTEE

This committee did not meet and has made no further study of the feasibility of establishing an association similar to the one in operation in Michigan. It therefore has no recommendations to make.

A. L. VASCONCELLOS, M.D.

Association of Professions Study Committee

It is recommended that the study be continued and developed.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

NURSES' LIAISON COMMITTEE

The Committee was appointed late in the year and no specific occasion for a meeting has arisen since the origin of the Committee. However, an exploratory meeting with the Hawaii Nurses Association Liaison Committee is planned in the near future.

JAMES W. CHERRY, M.D.

Nurses' Liaison Committee

Your reference committee recommends acceptance of this report.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

LEGISLATIVE COMMITTEE

The Legislative Committee began meeting on August 12, 1960, in preparation for the Second State Legislative Sessions, and met every month or two until March 3, when the meetings were scheduled for every Friday afternoon at the Mabel Smyth Building. In the preliminary meetings, bills that the HMA would like to see enacted were discussed. These included:

1. *Liability of Physicians Rendering Emergency Treatment.* (HB 457, SB 581): This was drafted by Mr. Kennedy and the Legislative Reference Bureau and introduced by Trask. (Dr. Hartwell was selected to bird-dog this bill during the coming session.)
2. *Medical Research and Animal Experimentation.* (HB 815): Mrs. Devereux was appointed to have this bill drafted. (Dr. Brainard was selected to bird-dog this bill during the coming session.)
3. *Legislation Relating to Confidential Information.* (HB 1301): Mrs. Devereux had this bill drafted, it was introduced by Robert Chang. (Dr. George Goto offered to bird-dog this bill.)
4. *Donations of Dead Bodies and Parts Thereof for Medical Use.* (HB 386): Mrs. Devereux had this bill drafted. (Drs. Mermod and Frissell will bird-dog this bill.)
5. *Cancer Quackery.* (HB 387): Mrs. Devereux will have this bill drafted. (Dr. Batten will bird-dog this bill.)
6. *Medical Practice Act.* (HB 459): Mr. Kennedy had this bill drafted according to the recommendations of the ad hoc committee. (Dr. Richardson will bird-dog this bill.)

Other subjects discussed at length in anticipation of legislation that might be forthcoming included autopsies, aging commission, health insurance for State employees, financial support for an alcoholic clinic, implementation of the Mills-Kerr Bill and Bureau of Sight Conservation.

In an attempt to obtain as much information as possible on the above subjects, various doctors in the community with particular interest in these subjects talked to the members of the Legislative Committee.

For additional help during the legislative session, Renfro Hoskins, a law student from the University, was employed to do the leg work and obtain the bills and schedules of hearings.

A party was given for legislators on March 6, 1961, at Queen's Surf, in an effort to get more of the doctors interested in politics.

The first weekly meeting took place on March 3, 1961, and these meetings are continuing through this session. The resumé of the bills to be discussed at each weekly meeting is sent out to the members of the Legislative Committee in advance of the meeting and at the meeting all bills that have medical significance are graded, according to how active the Medical Association should be either in favoring or opposing a bill.

Our main concern has been with the seven bills introduced in the House that would amend the Medical Practice Act. There are many forces at work trying to lower the requirements for licensure, to allow more foreign graduates to be examined for licensure in Hawaii, to allow more Kaiser Doctors into the state. House Bill #970, if passed, would allow reciprocity with any state without examination. The dropping of the one-year residence requirement is also being seriously considered by the Legislature.

The pharmacists have been very cooperative in backing the medical profession and exerting extra pressure on their political friends on our behalf.

I should like to recommend: (1) That the annual party given by the Association for the legislators be continued; (2) that more doctors become interested in their future by becoming active in politics and joining the party of their choice, participating at a precinct level: (3) that the allotment be continued to provide extra help to the Executive Secretary during the legislative sessions; (4) that more doctors participate as legislative committee members or as volunteers to testify at hearings of the legislature after preliminary meetings with the Legislative Committee.

LEABERT R. FERNANDEZ, M.D.

Legislative Committee

Your reference committee recommends that the report of the Legislative Committee be accepted. Furthermore, we would like to emphasize the following:

(a) That in the event the Medical Practice Act is passed without the requirements of the ECFMG test, that the Governor be approached by the Medical Association with an urgent request for veto of the bill.

(b) That the Legislative Committee explore the feasibility of employing a full-time legislative lobbyist for H.M.A.

(c) This Committee believes it is extremely important to have uniformity of action in the presentations made at legislative hearings. Furthermore, for the purpose of presenting uniformity of thought, all testimony should be cleared through the Legislative Committee of H.M.A.

(d) It is the feeling of this reference committee that the membership has not been adequately informed of the Legislative Committee's actions and better and more effective lobbying and liaison between this Committee and the membership of the Association is to be desired.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

THE MABEL SMYTH BUILDING BOARD OF MANAGEMENT

During 1960 the Hawaii Medical Association was represented on the Board of Management by Dr. Harry L. Arnold, Jr., and Dr. Masato Hasegawa. Dr. Toru Nishigaya replaced Dr. Arnold at the end of the year and Dr. H. Q. Pang became the alternate. The Hawaii Nurses' Association was represented by Mrs. Esther Stubblefield and Mrs. Mary Marshall Walsh. The Queen's Hospital was represented by Mr. A. J. Hebert.

Activity in the building shows a marked increase, 6,476 over 1959.

Auditorium was used	175	times	30,856	present
Committee Meetings	289	"	4,116	"
Refreshments served	40	"	2,913	"
Total			37,885	"

Renovation in the first floor area has been completed and we do not have any outstanding bills.

Financially we are improving our situation. After transfering $2,692.66 to the Building Fund there was a net increase of $936.90.

In December we put the money from our Building Fund into a savings and loan account. This will be increased by $1,500.00 every six months and is allocated for depreciation.

On the Nurses and Physicians Exchange we had an increase of ten members in 1960. The Exchange handled the following:

Incoming calls	51,137
Outgoing calls	33,715
Total	84,852

The Exchange also processes the calls for the Mabel Smyth Building and the Emergency Call Service.

It is a little premature in the planning to make definite statements concerning the additional space which we expect to have in the building. However, we can predict some developments in the near future. It may even be that by the time this report is distributed we will have more news for you.

MASATO HASEGAWA, M.D.

Mabel Smyth Building Board of Management

It is recommended to accept the report. In addition, we would recommend utilizing the basement area of the Mabel Smyth Building for futrher expansion, if needed.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

ADVISORY COMMITTEE TO THE BUREAU OF WORKMEN'S COMPENSATION

No meeting was called during the past year and as a result no business was transacted.

ANDREW L. MORGAN, M.D.

Advisory Committee to the Bureau of Workmen's Compensation

Your reference committee recommends the termination of the Advisory Committee to the Bureau of Workmen's Compensation. In its place we recommend that the Council investigate the feasibility of establishing a liaison committee with the Director of the Department of Labor and Industrial Relations, under whose jurisdiction lies the Bureau of Workmen's Compensation.

ACTION:

The chairman moved adoption of this portion of the report.

Dr. Cushnie asked for discussion on this report. Dr. Vasconcellos said that unless the Director of the Department of Labor asks for liaison, the Medical Association cannot force a committee upon him. Dr. Berk said that as an advisory committee, it is on call but the committee has not been called. The reference committee thought it would be better to go right to the head of the Labor Department and let him know there is a committee of doctors and let him know that they are willing to help in any way they can. Dr. Vasconcellos noted that when he was on this committee, the meetings were always set up at a time when the doctors could not attend. Dr. Cushnie said that the Fee Adjustment Committee had many meetings with the Bureau. Dr. Giles felt some care should be used in making our approach. In recent meetings Mr. Douglas showed the members that he was actually a friend to the Medical Association. Dr. Berk said this was not meant as a reproach but that it might make the committee more effective. Dr. Nishigaya questioned the implementation of the reference committee's recommendation.

Dr. Nishigaya moved, seconded by Dr. Mills, the last sentence of the reference committee report be amended. In its place we recommend that an ad hoc committee appointed by the President investigate the feasibility of establishing a liaison committee with the Director of the Department of Labor and Industrial Relations, under whose jurisdiction lies the Bureau of Workmen's Compensation. The amendment was adopted.

The report was adopted as amended.

RESOLUTION RE HONOLULU FOUNDATION

WHEREAS, the Honolulu Foundation for Medical Care has been incorporated to sponsor adequate pre-paid medical care programs agreeing to accept adequate fees as full payment thereby giving patients the certainty of coverage and the predictable costs that they desire,

WHEREAS, these programs are available to all service plans, insurance carriers, and all other pre-paid medical care programs including those financed by governmental funds, and

WHEREAS, this sponsorship provides opportunity to the local medical profession to assume responsibility and leadership in the area of "quality control"; therefore, be it

Resolved, by the House of Delegates of the Hawaii Medical Association that this body endorse the Honolulu Foundation for Medical Care, and be it further

Resolved, that this body recommend to all medical societies in Hawaii their support of the Honolulu Foundation for Medical Care.

Introduced by
GEORGE H. MILLS, M.D.

Resolution re The Honolulu Foundation

Your reference committee recommends adoption of this resolution and recommends that more detailed plans of the Foundation be disseminated to the other county medical societies.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

MEMORANDUM RE HAWAII MEDICAL PAYMENTS PROGRAM

We would like an opportunity to submit, for the information of the delegates to the Hawaii Medical Association, material regarding the State Medical Payments Program for Indigents and Medical Indigents.

The following material, which was developed primarily by Dr. John Devereux, Medical Consultant, is original draft material and is by no means final. It will be subject to further review and revision.

However, when we learned of the annual meeting of the HMA, we decided to submit our beginning material to you and to receive your Association's comments on it.

We also hope that we might be given an opportunity to meet with the delegates to answer questions or provide additional information they may desire on this matter.

We hope that the material will increase your Association's understanding of the Medical Payments Program and that your members will give us the benefit of their thinking.

Please let us know of your disposition of this request.

(s) MARY L. NOONAN

Present Structure of the Medical Payments Program

A. Persons eligible for service through the Medical Payments Program are:
   1. "Indigent"—a person who is receiving economic assistance (food, shelter, clothing, etc.) from the Department of Social Services.
   2. "Medical Indigent"—a person otherwise able to subsist himself but who is unable to meet medical expenses.

B. Under the existing law (Chapter 48, RLH 1955) both the State and the four county governments are involved in the administration of the Medical Payments Program.
   1. The State (Department of Social Services):
      a. Determines eligibility of "Indigent" group.
      b. Makes semi-annual allocations of State Medical Payment monies to each county.
      c. Makes payments to 40 government physicians in areas outside of City of Honolulu.
      d. Provides over-all administration of program, including statewide accounting of expenditures.
      e. Accounts to the Federal Government relative to expenditures in certain categories (Old Age Assistance, Aid to Blind, Aid to Disabled, and Aid to Dependent Children).
   2. The four county governments, in their respective counties:
      a. Determine eligibility for "Medical Indigent" group.
      b. Make payments to vendors for services rendered to both indigents and medical indigents.
      c. Account to Department of Social Services as to their expenditure of State Medical Payments funds.
      d. Meet, through county funds, deficits incurred in the program.

Proposed Structure of the Medical Payments Program

The State Legislature is now considering a bill which would effect the transfer to the State of functions in the Medical Payments Program that are now being carried by the four county governments. If such a transfer is approved, the State (Department of Social Services) would:

A. Determine eligibility of both "indigent" and "medical indigent."
B. Administer all aspects of the program, including total financing.
C. Make direct payments to vendors furnishing medical care.
D. Continue to make payments to 40 government physicians.
E. Continue to report to Federal Government regarding expenditures in certain categories.

The Department of Social Services is highly in favor of such a transfer because it would result in:

A. Uniform eligibility standards throughout the State for care under the Medical Payments Program.
B. Sounder and less complicated payments administrations with centralized control.
C. Elimination of duplication of certain administrative procedures which now exist.
D. Increase in Federal matching funds to the State, including legal qualification for Federal funds made available under the 1960 Kerr-Mills Act (Medical Assistance for the Aged).

Department of Social Services Medical Payments Program for Indigents and Medical Indigents

Medical care is essential for individual well-being. Its objectives include the promotion of health, the prevention of disease and disability, the cure and mitigation of disease, and reduction, if not prevention of, disability, economic insecurity, and dependency associated with illness. Medical care includes the rehabilitation of the patient and his restoration to productive living.

In financing the cost of medical care of indigents and medical indigents in Hawaii, the Department of Social Services believes that it should be administered in such a manner as to assure economy, without sacrificing quality of care, and in accordance with the Department's over-all mission to preserve, improve, and protect the human resources of the State.

Content of Medical Services in the Medical Payments Program

The Department of Social Services believes that it should finance the cost of such medical care as is necessary to: Save life, Relieve suffering, Prevent significant deterioration in health, Improve function for self-care and independent living, and Rehabilitate the individual back into the community.

Services that should be provided under the Medical Payments Program should include:

1. Professional practitioner's services: doctors, dentists, medical and surgical consultants, optometrists, ophthalmologists, physiotherapists, and nursing.
2. Inpatient hospital care in general or specialized hospitals.
3. Nursing home care.
4. Diagnostic laboratory services.
5. Radium and x-ray therapy.
6. Surgical appliances and prostheses.
7. Drugs.

All care to be paid for under this program should be "necessary" and "reasonable," in relation to the needs of the individual patient, and not merely "desirable" or "convenient."

The Department of Social Services will coordinate its program with the programs of existing public and private agencies providing or purchasing health and medical services. Thus, the Medical Payments Program will not pay for the following services:

1. Tuberculosis care.
2. Venereal disease care.
3. Hansen's disease care.
4. Psychiatric care.
5. Burials.
6. Coroner's services.
7. Operation of first aid stations or services provided therein.
8. Transportation services except for authorized air travel for referred cases.
9. Domiciliary care.
10. Care of pensioners as such.
11. Hospital boarders not requiring active medical supervision.

Provisions of Medical Services

Services to be paid for through the Medical Payments Program shall be provided, at this time, through:

1. Outpatient clinics in the City of Honolulu.
2. General and specialized hospitals throughout the State.
3. State Government Physicians in Rural Oahu and in Hawaii, Maui, and Kauai Counties.

The above-noted method of providing services under the Medical Payments Program will continue indefinitely, unless other methods are found to be more feasible, and will result in greater benefit to the people of the State.

The Department recognizes the need to consult with and secure the thinking of the medical profession. Thus, no major change will be instituted in program methods or other professional aspects of the program without consultation with the medical profession.

Professional Aspects in the Administration of the Medical Payments Program

Professional advice and direction in the administration of the Medical Payments Program will be provided by:

1. Departmental Medical Consultant.
2. Medical Advisory Committee.
   This committee will include representation from the medical, dental, pharmacy, nursing, hospital administration, and social work professions.

In addition, the respective professional organizations will be consulted as it concerns specific areas in the program. It is felt, however, that close liaison will be required with the Hawaii Medical Association, inasmuch as medical services constitute the major service to be purchased under the Medical Payments Program.

Report re Hawaii Medical Payments Program

Your reference committee believes that the total medical program for the indigent and medically indigent is the proper province of the Department of Health and until such time as this transfer can be accomplished by the Legislature, the following recommendations are in order:

(a) That a Medical Advisory Committee consisting of physicians of the H.M.A. be the sole Medical Advisory Committee to the Department of Social Services.

(b) That representatives of this Committee be selected to sit with the over-all Advisory Committee to the Department of Social Services which includes physicians, dentists, social workers, etc. It is our contention that medical activities per se should receive the direct attention of the physicians only.

ACTION:

The chairman moved adoption of this portion of the report.

Dr. Cushnie asked for discussion on this report. Dr. Mills noted that the committee that is being formed by the Department of Social Services will consist of many disciplines. There will be only one or two doctors in it and the effectiveness of our representatives will be fairly well diluted. Dr. Hartwell thought that the HMA should take a very strong stand on which department of the government the care of the indigent should be in. He told some of the background of how the change was effected. Perhaps not this year or next, but eventually he thought the medical care of the indigent would go back to the Department of Health and this would not interfere with the implementation of the Kerr-Mills Act.

Dr. Berk amended Section (a) of this portion of the report to read "That a Medical Advisory Committee consisting of physicians of the HMA be the sole Advisory Committee on medical matters to the Department of Social Services." The amendment was adopted.

The report was adopted as amended.

Resolution re Narcotic Addicts

WHEREAS, the American Medical Association and the American Bar Association have had committees studying the problem of narcotic drug addiction, and

WHEREAS, the only adequate and successful treatment of narcotic addiction necessitates constant control in a secure institution affording a drug free environment, and

WHEREAS, experience has shown that treatment of narcotic addiction by means of various types of ambulatory clinic plans has been universally unsuccessful, impractical and scientifically unsound, and

WHEREAS, in all attempts of treatment of narcotic addiction by ambulatory methods, addiction has in fact increased, therefore, be it

Resolved, that the Hawaii Medical Association expresses the opinion that the ambulatory clinic plan for the treatment of narcotic addiction is inadequate and medically unsound; and be it further

Resolved, that the Hawaii Medical Association delegates to the American Medical Association be instructed to oppose

the development of any such ambulatory treatment plans, although it is not intended in any way to oppose, after complete withdrawal, follow-up treatment at rehabilitation centers, and to support (1) measures designed to require the compulsory civil commitment of drug addicts for treatment in a drug institution, (2) to advance methods and measures toward rehabilitation of the addict, and (3) to establish methods for the dissemination of factual information on narcotic addiction to the members of the medical profession.

Introduced by:
MORTON E. BERK, M.D.

The Resolution re Narcotic Drug Addiction

Your reference committee has not had sufficient time to study the background of this problem and therefore your reference committee recommends that this resolution be not adopted.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

The chairman moved adoption of this report as a whole as amended. It was adopted.

MISCELLANEOUS BUSINESS REFERENCE COMMITTEE

Mr. President and members of the House of Delegates:

Your Reference Committee on Miscellaneous Business gave careful consideration to the matters referred to it and makes the following report:

AMERICAN MEDICAL EDUCATION FOUNDATION

Although not complete, our records show that 288 Hawaii doctors contributed $4,998.50 to the American Medical Education Foundation between March 1, 1960, and January 31, 1961. This compares favorably with last year's total of $3,910.00 from 83 contributors. The total figure includes the substantial fund raised by the Woman's Auxiliary. By the end of the AMEF fiscal year, we should reach $7,000.

We will reach this figure mostly because of Dr. Kiyoshi Inouye, who received an award of merit for his 1960 contribution. In February, 1961, he gave $1,000 to the AMEF. Our salute to him! He is a credit to the medical profession here and to his alma mater.

Two projects were directly carried out by me: (1) An appeal letter to every registered physician in this state, and (2) the enclosure of envelopes with the January, 1961, Newsletter.

There has been increased interest in this worthy project here and throughout the nation. Private medical schools do not report the donations they receive to the AMEF. If that figure were known, I am certain the total from Hawaii would exceed $10,000.00 Physicians who graduated from China, Japan, the Philippines, Canada, and some European countries have not seen fit to voluntarily donate to the AMEF.

The next chairman of the AMEF of the Hawaii Medical Association may come up with some idea of reaching this particular untapped group. I hope the next chairman to be designated by the new president will increase contributions much more in the next fiscal year.

MIN HIN LI, M.D.

American Medical Education Foundation

Your reference committee recommends approval and acceptance of the report and further recommends to the Council of the Hawaii Medical Association that it again include in its budget some funds for the use of the A.M.E.F. and also that the Council write a letter of appreciation for the splendid work that Dr. Min Hin Li has done in this endeavour.

ACTION:

The chairman moved adoption of this portion of the report.

ARRANGEMENTS COMMITTEE

The Arrangements Committee, at the suggestion of the previous committee, met early in the year to decide upon the place of the meeting. The Princess Kaiulani Hotel was chosen because of the poor acoustics at the previous meeting. For the benefit of future committees it should be noted that the Sheraton Hotel people were less than cooperative in all respects.

Your Committee made certain changes in policy, as follows:

1. Scientific exhibitors be charged in accordance with the basic rates for the space they occupy. Local member exhibitors will be given financial relief through the HMA at the discretion of the Arrangements Committee.
2. Because of the deficit in the Golf Committee funds, no pictures of the golf tournament and picnic were authorized. Subsequently, Dr. Gilbert Halpern offered to take photographs of the picnic at no cost to the Association and Drs. Joseph Palma and Toru Nishigaya have volunteered to defray the cost of color movies of the golf tournament.
3. The golf tournament fees will be included in the registration form. These fees are to include a contribution to help defray tournament expenses.

For the benefit of the ensuing committee, arrangements for the golf tournament should be made as soon as the meeting dates are determined: It was necessary to change the tournament from Waialae Country Club as planned to Oahu Country Club because firm dates were not secured in time.

The chairman wishes to thank the members of this Committee and the Executive Secretary who have given so unselfishly of their time in arranging this meeting.

RICHARD D. MOORE, M.D.

Arrangements Committee

Your reference committee recommends that the last sentence of paragraph one of the report be deleted even though there was some misunderstanding between the Committee and the Sheraton Hotel people. Your reference committee also wishes to acknowledge with thanks the generosity of Drs. Joe Palma and Toru Nishigaya in defraying the expenses of the golf movies. It is also recommended that the next committee be activated early in the year again.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

EMERGENCY MEDICAL SERVICE COMMITTEE

The Emergency Medical Service Committee changed chairmanship in August of 1960 and entered into a new phase of activity. Heretofore, the emphasis had been upon organizing and assigning physicians and dentists to hospitals and aid stations as well as establishing an over-all plan within the Civil Defense framework. Attention had also been given to the organizing and assigning of nurses and technicians through their respective organizations. While these broad aspects of the medical defense organization are largely under the direction of the State Department of Health, it is essential to understand that the physicians of Hawaii must set a pattern of activity, must undertake the requisite training programs, and must lead the way generally towards an effective plan of medical preparedness, whether it be for a local disaster situation or for an enemy nuclear attack.

In November of 1960 the Committee Chairman attended the Eleventh County Medical Societies Conference on Disaster Medical Care, sponsored by the Council on National Security, AMA, in Chicago. Much of this conference was devoted to methods for implementation of local planning and training with considerable emphasis on the use of the 200-bed Civil Defense Emergency Hospital. From the standpoint of planning and organization, Hawaii ranks far ahead of most of the states, and the measures already achieved in the stockpiling of equipment and drugs are impressive. For these accomplishments credit is entirely due to the efforts of the State Department of Health, which in Hawaii directs and coordinates all emergency medical and health services for the Civil Defense organization.

The current field of activity of this Committee is the testing of the respective Disaster Plans of the major Honolulu hospitals. Two such "dry runs" were scheduled to take place during the Civil Defense nation-wide "Operation Alert," using actual mock casualties on litters. It is contemplated that in the ensuing year a city-wide exercise embracing all hospitals and several aid stations may be correlated with the Civil Defense exercise. Such will obviously require much planning and preparation, while the anticipated community participation and interest in such a project should be stressed for its positive public relations benefit to the medical profession.

Four meetings of the Committee were held in addition to the hospital disaster plan exercises. There was also a well attended lecture by Col. Joseph Goldstein of the Surgeon General's office on "The Care of Mass Casualties." Recommendations for future activities of this Committee include updating of assignments, continued hospital testing, setting up of a 200-bed Civil Defense Hospital for practice and public demonstration, and some effort to organize and train Aid Station personnel.

EDWARD W. BOONE, M.D.

Emergency Medical Service Committee

Your reference committee recommends approval of this report and wishes to commend Dr. Edward Boone and his Committee for the outstanding job that he has done in this field. Your reference committee further recommends that the President of the Association confer with the Chairman of the E.M.S. Committee so that the appointments of interested physicians be made to help in this important work, and that the Committee attempt to interest more medical participation through local medical society activity.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

AWARDS COMMITTEE

The Awards Committee, consisting of Drs. Robert Katsuki, H. Q. Pang, Nishigaya, and the undersigned, met on March 20 and agreed on the nomination of Dr. N. P. Larsen to receive the Oahu Health Council's annual award for community service in the field of public health.

On April 3 they met again and reviewed the qualifications of several potential candidates for the first annual Public Service Award to be made by the Association through the generosity of the A. H. Robins Company. The committee unanimously agreed the doctor who will be named on May 5 had made the outstanding record for community services, and selected him as the first recipient of this award. His activities this past year included the following: Director of his community association; Moderator of his church; member of the Lions Club, Child and Family Service, Oahu Health Council; Chairman of the Public Health and Safety Committee for his community association; team physician for community Pop Warner football team; conducted educational programs on cancer, tuberculosis, medical insurance, and emergency resuscitation; conducted marriage clinics, and a drive to purchase wheel chairs and furniture for Waimano Home; instrumental in organization of Professional Men's Association golf club, President of his community baseball club, Vice-president of the Professional Men's Association.

No selection was made this year for a recipient of the Distinguished Service Award of the Hawaii Medical Association.

HARRY L. ARNOLD, JR., M.D.

Awards Committee

Your reference committee recommends approval of this report and suggests that the Council of the H.M.A. thank the A. H. Robins Company for this Public Service Award, and further recommends that the Awards Committee be a permanent one and that further investigation be made into the Distinguished Service Award of the H.M.A.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.



The Robins Award for outstanding community service is made to Dr. Joseph T. Nishimoto of Pearl City by Pres. Edward F. Cushnie (left) and Mr. James R. Patterson of Robins (right).

HAWAII MEDICAL JOURNAL

The JOURNAL is on the verge of completing its twentieth year of existence, and although financing it has been made somewhat more difficult by the recent nation-wide cutbacks in pharmaceutical advertising, it is still in a reasonably sound financial position. Aside from the fact that it is the only state journal (except *Alaska Medicine*) published less often than once a month, we think it is still a magazine we can be proud of.

The following tabulation shows that in the past six issues we have had an average of only 60 pages of advertisements (only 52 pages in the two 1961 issues published so far!) instead of the 80 pages averaged in the preceding year. The average size of each issue has had to be cut from 130 pages to 104 as a result. We still managed to print an average of 19 pages of scientific articles in each issue—26 articles altogether, including the lengthy 1960 "Hiscock Report." Our backlog of material is a little larger than we would like at the moment, and articles are waiting close to six months for publication.

AVERAGE NUMBER OF PAGES PER ISSUE

	1958-59	1959-60	1960-61
Scientific	16	18	19
Features	22	24	17
Nurses	8	8	8
Advertisements	61	80	60
TOTAL	107	130	104

Since the JOURNAL expense is now tabulated with the budget, it can be checked by reference to the Treasurer's report. A profit of $1,629—even with $3,649 in prorated salaries debited against the JOURNAL—was shown for the fiscal year. A deficit of $1,490 is projected for next year.

Forty-five signed book reviews and 107 unsigned "thumbnail" reviews were published, and the books donated to the Hawaii Medical Library, during the fiscal year. The Hawaii Technologists' Bulletin; the Infant Death Case Study Reports; In Memoriam—Doctors of Hawaii; and This is What's New have almost finished their first, second, fifth and fifteenth years respectively. Dr. Momeyer resigned as News Editor, and the job is currently being done very well by Dr. T. Nishigaya. Summaries in Interlingua have been discontinued.

What to do about the projected deficit? We suggest that nothing positive be done at the moment, except to approve the Treasurer's recommendation of an increase of the subscription price to $6, because (1) the advertising picture may change at any time—for the better, we hope; (2) even with the deficit, it would actually cost us money to discontinue publication, since the prorated portions of salary would

have to be paid from the Association's General Fund: (3) there isn't really any material that could easily be cut from the magazine, with the possible exception of the Inter-Island Nurses' Bulletin, and the nurses are again considering publishing their own magazine.

We recommend, in summary, that the subscription price be increased to $6 for physicians and $3 for nurses and technologists, and that the Council be designated as Publications Committee for the HAWAII MEDICAL JOURNAL.

HARRY L. ARNOLD, JR., M.D.

Hawaii Medical Journal

Your reference committee recommends adoption and approval of this report and also recommends that the subscription rates be raised to $6.00 a year and that the Council be designated as the Publications Committee for the HAWAII MEDICAL JOURNAL.

ACTION:

The chairman moved adoption of this portion of the report.

Dr. Berk asked why the Council had been appointed Publications Committee and Dr. Sloan advised that this was done on advice from Dr. Arnold since previous recommendations had not been implemented.

The report was adopted.

HAWAIIAN ACADEMY OF SCIENCE

The Science Fair has as yet not taken place, but the society is backing it as usual. Since this is good public relations and of value for the future, it is recommended that the Medical Society backing continue to the same extent.

W. HAROLD CIVIN, M.D.

Hawaiian Academy of Science

Your reference committee recommends approval of this report and also recommends continued financial support of this worthy project.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

PHYSICIANS' AID COMMITTEE

The committee discharged its duty with the mailing of bills for the voluntary assessment authorized by the last meeting of the House of Delegates.

The response to the first year's billing was fairly good. Some doctors paid their five year assessment with one check. The total collected in 1960 was $3,875.00.

It is recommended that this ad hoc committee be disbanded; that bills for the assessment be sent out yearly until $25,000.00 is collected and at that time the trust be set up as authorized by the 1960 meeting of the House of Delegates.

FREDERICK L. GILES, M.D.

Physicians Aid Committee

Your reference committee, after considerable discussion, recommends that the Committee be continued in order to determine the tax obligations of this fund and to investigate the possibility of investing part or a major portion of its money in stocks or larger return interest institution, and supervise the management of the fund. Your committee wishes to commend the ad hoc committee for a job well done.

ACTION:

The chairman moved adoption of this portion of the report.

Dr. Waite pointed out that the Internal Revenue Service already reported to the committee that there will be no tax problem. Dr. Sloan said his reference committee did not have access to this information. They felt that even so the committee should continue. Dr. Giles said the committee felt that the Treasurer should supervise these funds and that he could go into this to see that there is proper control. Dr. Sloan said that the ad hoc committee requested to be discontinued and the reference committee did not concur with this request. Dr. Brown said that he felt a fund like this should not be invested in stocks unless it is under a trust. Dr. Waite said that the reference committee report adopted two years ago stated exactly how the money was to be invested. Dr. West read from the minutes of the 1959 meeting in which it was set forth how the funds should be handled. It was noted that the amount collected each year is to be turned over to the committee and that the five year period refers to the stipulation that no money be disbursed.

Dr. Sloan amended the second sentence of the reference committee report to read, "Your reference committee recommends that the President appoint a committee as directed in the previous reports of this House."

The report was adopted as amended.

SCIENTIFIC PROGRAM COMMITTEE

The Scientific Program Committee for 1961 consists of Drs. Ralph M. Beddow, Herbert Y. H. Chinn, W. Harold Civin, Grant N. Stemmermann, A. Leslie Vasconcellos, Vernon G. Boido, James A. Mitchel and Clifford F. Moran. In addition, six members of the Association agreed to organize the panels: Drs. Unoji Goto, Chew Mung Lum, John M. Ohtani, Richard K. B. Ho, William Moore and George Oakley. The central theme of the scientific program of May 4 to 7, annual meeting is to deal with emergencies in the major fields of surgery.

Two of these panels are to be held each morning on March 4, 5 and 6. The evening speakers are to be Dr. John W. Cline, President of the American College of Surgeons and past President of the American Medical Association, who will speak on *Advances In Therapy Of Malignant Diseases,* and Dr. Walter C. Alvarez, Editor of *Modern Medicine,* who will speak at both of the evening sessions.

I wish to express gratitude for the support of the Committee members and for their suggestions and particularly to those members who volunteered to organize the panels. I also wish to express my keen appreciation for the assistance given by Miss Lee McCaslin, our Executive Secretary.

JAMES W. CHERRY, M.D.

Scientific Program Committee

Your reference committee recommends approval of this report and wishes to commend the Program Committee for an outstanding job in arranging such a well balanced and informative scientific program.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The Woman's Auxiliary to the HMA had no problems which needed to be reviewed or discussed by the Advisory Committee.

Mrs. Howard Liljestrand, the Auxiliary President, called me on a few occasions regarding minor policy matters which I did not feel of sufficient importance to call a meeting of the Committee.

HOMER R. BENSON, M.D.

Advisory Committee to the Woman's Auxiliary

Your reference committee recommends adoption of this report and commends the chairman for resolving the problems with the minimum amount of difficulty.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

THE WOMAN'S AUXILIARY TO THE HAWAII MEDICAL ASSOCIATION

The state auxiliary is in business. Thanks to the action of the H.M.A. Council in August of 1960, our financial footing

is for the first time adequate. Because of this, we have been able to plan a budget which will enable our committee chairmen to plan goals and work toward their accomplishment.

This is particularly evident in three outstanding projects:

(1) Our state safety chairman, also functioning as Honolulu County safety chairman, has, under the auspices of the county, and with her county committee, been working on a program for education of the public in regard to safety from poisoning in the islands. This will be developed through a slide library of poisonous local flora and fauna and ordinary unsuspicious looking, but poisonous, household products. A speech on tape will be made to accompany the slides when loaned out to organizations, schools and groups throughout the state. Local talent among doctors' wives is producing the program, even the photographic work, thereby keeping the expenses low. The state auxiliary has been able this year to hasten the culmination of this project by contributing one hundred dollars toward it. This program will further good public relations in the community.

(2) Our In Memoriam project has been mentioned briefly in annual reports for eight years, having been initiated in the year 1953. During this time, a total of 334 physicians' biographies have been written, and for 72 of these, photographs have been procured. This project was suggested by Mrs. Warren White, who has assisted with the work, but largely the doctors of Hawaii owe a debt of gratitude to Mrs. Robert Katsuki, who has almost singlehandedly produced the three volumes now in existence. This has been accomplished by giving a tremendous number of hours to research in the Archives and in the Public Library, where she has perused every edition of local newspapers from the very earliest days. She is now reading the news of the year of 1894. In addition to her research on ancient history, she keeps an up-to-date record on present day activities of all physicians in the islands, clipping avidly and filing—for future use. Four copies of these three volumes are in existence, one each on Kauai, Maui, Hawaii and Oahu. Although we think of this project as largely benefiting and pleasing the people within the profession, it may also be said to have community significance. Maui has recognized this by placing its copy in the Public Library. The other three islands have placed theirs in Medical Libraries. The Archives have requested a copy. The speed with which this committee could produce has been limited by an extremely small annual allowance. Because of the present financial picture, we have been able to budget one hundred and fifty dollars for this committee for the 1961-1962 year, a figure six times that on which it has been functioning, a figure which will allow the committee to more rapidly process the biographies and procure photographs.

(3) The third project which we hope to benefit by our financial freedom is none other than the Physician's Benevolent Fund, established by the Hawaii Medical Association. We have budgeted to contribute four hundred dollars to this Association fund during the following year.

Along with the pleasure of being able to do business more adequately, because of this improvement in our financial position, have come also minor problems caused by the mechanics of change in the financial relationship of state and counties. These are only temporary problems needing a little time, effort and experience to solve. Bylaw changes are being presented at our convention meeting. The compilation of a complete list of doctors' wives in the state, with residence addresses, has been accomplished by our secretary and her committee, and addressograph plates are now being made from the list.

The primary purpose of having an organized, functioning auxiliary to the medical profession is to have a group standing by ready to assist the doctors whenever called upon to do so. During this year we have given assistance by staffing, for one week, the clinitron unit used in the diabetes detection drive, distributing poison prevention cards to 51,000 homes, hand printing invitations for the legislators' dinner, telephoning when requested, helping with several conventions, including the large Pan Pacific Surgical Convention and the state convention now in preparation. In addition to staffing the information and registration desks for these conventions, and meeting and entertaining visitors, there is always the decorating for banquets, and assisting in other small but time consuming errands and duties. We assisted the doctors by handling the details in Hawaii of the national essay contest conducted by the Association of American Physicians and Surgeons Freedom Program through the schools of the nation. Another project suggested by the men, and now being executed, is the naming of all individuals in the state convention photographs that have been accumulating without identification for several years. The doctors have also asked for assistance in legislative matters, and workshops for education of the public are now being set up.

Physicians' wives continue to give to their respective communities very large amounts of time both directly through the auxiliary and through their other community interests. The twenty-six members on Maui and thirteen on Kauai have given generously to service projects, and the women of Kauai have contributed toward recruitment for health careers in their area.

A representative of our auxiliary was invited to attend a meeting of the Auxiliary to the Hawaii Dental Society; another attended the National Security Seminar sponsored by the Junior Chamber of Commerce and given by the Industrial College of the Armed Forces; also we were represented at the Aircade for Citizenship Action, and the one-day Seminar on The Older Worker. Our civil defense chairman was requested by the Mayor to aid in preparing a television film strip on "Home Preparedness," which was shown on "The Mayor Reports" and is available for re-run.

Programs have included such educational subjects as a tour for members of the Diamond Head civil defense installations, Waimano Home, and the annual lay-day program, this year on the subject of alcoholism, to which presidents of many women's organizations in Honolulu were invited.

The Honolulu County Auxiliary did a tremendous job for The American Medical Education Foundation, during the 1959-1960 year, and was recognized at the national 1960 convention. This signal honor has not been reported to the Medical Association. Through their tremendous efforts, Hawaii was granted, for the third time, a merit award, this time as the very first in the entire nation. This is figured on a per capita basis. Our total contribution to A.M.E.F. over a period of four years has amounted to $6,288.00.

It has been a busy year (246 letters written and received). I contributed the presidential article for the March issue of the National Bulletin; attended and reported at the National Convention in June of 1960; and was asked to serve as a national regional chairman for 1961-1962. This honor had to be declined with regret because of travel time and expenditure required. I have enjoyed serving this busy group, and thereby being identified with that impressive body, the Woman's Auxiliary to the American Medical Association. Eighty thousand strong, they are potentially a powerful force in our nation.

The president has endeavored to foster good relationships between the state and the counties and between the counties and the community, for how the people of the community feel about the doctor's wife affects their attitude toward the physician and the medical profession. Tremendous changes have swept over America in the past few years, and apparently greater changes are coming. The medical profession is in for its share. We need informed members, who have an awareness of social and economic community problems, and who take an active interest in solving them, so as to salvage as much as possible of what is good. This type of member develops with education by enthusiastic, diligent leaders. We thank the Hawaii Medical Association for making it possible for us to send our president-elect to the national conference for the second consecutive year. Mrs. Joseph Andrews attended. Her report to our state conference made it very evident that she had gained much to prepare her to ably guide the Auxiliary in the coming year.

I should like to express appreciation to the immediate past president, Mrs. Homer Benson, for turning over the organization with an obviously greatly increased interest among the members, and for her assistance and guidance when called upon many times during the year. The advisory committee of the Hawaii Medical Association, composed of Drs. Homer Benson, F. L. Giles and H. Q. Pang, have also been willingly helpful and ever ready to assist. My thanks go

to them, and to Dr. Edward Cushnie, President of the Hawaii Medical Association.

Because our president-elect resides on a neighboring island, and because of my absence for several weeks during the year, the first vice-president, Mrs. Fred Lam, Sr., has contributed many more hours than normally called for from that officer. My gratitude is hereby extended to her, and to Mrs. Robert Dimler, Secretary, and Mrs. Charles Yamashiro, Treasurer. The duties of these two have been heavier this year because of the problems created by the change in system of dues collection. All of the board have been helpful, and to them, and to every member who has contributed toward a more effective organization, may I extend my gratitude and appreciation.

MRS. P. H. LILJESTRAND

Report of the Woman's Auxiliary to the Hawaii Medical Association

Your reference committee recommends approval of this report and wishes to commend the President and her members for an excellent job. The Committee wishes to point out the many projects of the Woman's Auxiliary and to commend the ladies in their untiring efforts on our behalf. The reference committee also desires to recognize the work done by the Honolulu County Chapter in behalf of the A.M.E.F. and for the meritorious award received by the Auxiliary for its tremendous job of contributing to this fund.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

Mr. Chairman, in conclusion, the Chairman of this reference committee on Miscellaneous Business wishes to thank the Committee members for their help in the preparation of this report and our reference committee also wishes to extend its thanks to the members who appeared before us to help in our deliberations.

ACTION:

The chairman moved the adoption of this report as amended as a whole. It was adopted.

PARLIAMENTARY AFFAIRS REFERENCE COMMITTEE

Mr. President and members of the House of Delegates:

Your Reference Committee on Parliamentary Affairs gave careful consideration to the matters referred to it and makes the following report:

BYLAWS AND PARLIAMENTARY COMMITTEE

Your Committee has over the last three years reviewed many state constitutions and bylaws and studied the problems of our organization in relation to our bylaws.

The Committee proposes the submitted revised bylaws of the Hawaii Medical Association and recommends their adoption at the annual meeting.

The Committee also proposes the concurrent amendment of the Charter of the Association and recommends its adoptions.

Proposed amendments to the Charter of Incorporation are:

1. Amend by striking out wherever it occurs the word "Territory" and insert the word "State."
2. Amend Article XI by striking out "in person or by proxy."
3. Amend Article XI by inserting after "corporation" the words "present and voting."

RICHARD E. ANDO, M.D.

Bylaws and Parliamentary Committee

Your reference committee reviewed the report and recommends its adoption. It recommends approval of the proposed amendments to the Charter of Incorporation.

The revision of the Charter and Bylaws of the Hawaii Medical Association, which appears on pages 21-27 of the Delegates' Handbook. Your reference committee recommends that the revised Charter and Bylaws be approved with the following amendments:

(a) In the Charter of Incorporation under Article VI, 2d paragraph, the words "the Councilors" be inserted after the word "corporation."
(b) In article XI that the phrase "all of the then members in good standing of the corporation" be deleted.
(c) In the Bylaws, Chapter III, Section 5. Under (c), (5) it is recommended that bond in the sum of $1,000 be increased to $2,500.
(d) Chapter IV, Section 2. Under (a), the word "consecutive" be inserted between the words "three" and "years."
(e) Chapter V, Section 2. Under (D) the sentence be revised as follows: "No Councilor shall serve as an elected delegate to the Association during his term as Councilor."

Your reference committee makes the incidental motion that the provisions of Chapter 2, Section 1, not take effect until January 1, 1962.

Your reference committee recommends referral of the revised Charter and Bylaws, as amended, to the general membership of the Hawaii Medical Association for adoption.

Your reference committee recommends a vote of appreciation to the Bylaws and Parliamentary Committee and its able Chairman, Dr. Richard Ando, for the many long hours of work expended.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

PERSONNEL COMMITTEE

The Personnel Committee consisting of Drs. F. L. Giles, Arnold, Cushnie and West met on several occasions in an attempt to solve the problems of increasing costs required to administer the business affairs of the Hawaii Medical Association including the publication of the JOURNAL and other necessary functions.

A study of the Honolulu County Society's salary schedule was made, as well as of the salaries of executive secretaries of most of the forty-nine other states. The salary which should be paid our executive secretary, we concluded, must be adjusted upward; however, it must be also realistically placed according to the duties which our executive secretary has to perform. Many of the states have additional duties for their executive secretaries, such as blood bank administration, etc. This makes it difficult to compare our situation here with others. It was felt by the Committee that a raise of $50 a month at the present time should be given to Miss McCaslin with a top of $10,000 a year; however, the top salary will be met as deemed feasible by the President and Council.

The problem of retaining help in the office of the Hawaii Medical Association to provide necessary secretarial and clerical requirements was discussed thoroughly. In past years there has been a tremendous turnover in help, resulting in low efficiency. It was felt feasible to raise the salary which we were willing to pay to the executive whose duties consist of secretarial and clerk-typist type of work to $325 a month, particularly in view of the fact that a very efficient person was obtainable at that time for the figure. Starting salaries for others there should be in excess of $300 a month if no suitable replacement is available at a lower figure. The Committee also felt that it was quite necessary to retain efficient secretarial help due to the fact that additional duties will be placed upon this office as a result of the new public relations program which has just been initiated.

F. L. GILES, M.D.

Personnel Committee

Your reference committee recommends action on the suggestions regarding pay raises for the Executive Secretary and the secretarial assistants.

ACTION:

The chairman moved adoption of this portion of the report.

Dr. Giles was asked to comment on the Personnel Committee report. He spoke on the turnover of personnel in the executive offices due to the low pay

schedule. He also advised that the committee had made a survey of state medical associations of comparable size to determine the pay scale prevailing in other states.

The report was adopted.

TREASURER'S REPORT

The General Fund as of December 31, 1960, as corrected by the auditor, was $30,547.98, which included cash on hand, cash in the bank, inventory, liabilities, furniture, etc. This represents a net increase of $3,503.95 over the amount reported December 31, 1959. A transfer of $5,000 was made from the checking account early in 1960 and resulted in higher income from interest. The following is the budget approved by the Council at its March 27, 1961, meeting.

BUDGET FOR 1961

	1960 BUDGET	1960 ACTUAL	1961 BUDGET
INCOME			
Dues	$19,050.00	$18,400.50	$22,000.00
Journal—see Schedule I	1,710.00	1,629.14	(1,490.00)
Annual meeting—see Schedule II	3,150.00	4,173.89	4,870.00
Interest	850.00	1,060.77	1,180.00
Miscellaneous	350.00	379.36	420.00
Total	$25,110.00	$25,643.66	$26,980.00
Public Relations Assessment	—	—	8,250.00
Total	$25,110.00	$25,643.66	$35,230.00
EXPENSES			
AMA Conventions	$ 4,100.00	$ 4,212.29	$ 3,300.00
Audit and accounting	1,000.00	950.00	1,100.00
Automobile expenses	600.00	600.00	600.00
Council expenses			
Travel	650.00	335.68	750.00
Meals and rooms	260.00	202.27	250.00
Per diem	230.00	50.00	190.00
Donations	330.00	325.00	330.00
Entertainment	200.00	314.49	200.00
Insurance	100.00	74.73	200.00
Health Education Committee	1,150.00	1,050.06	650.00
Library	100.00	100.00	100.00
Legislative Committee	1,000.00	802.66	1,500.00
Miscellaneous	200.00	247.63	300.00
Postage	950.00	752.77	750.00
President's Contingency expenses	500.00	104.91	300.00
Rent	1,850.00	1,848.00	1,850.00
Repairs and maintenance	150.00	91.71	100.00
Salaries	12,940.00	12,523.16	14,770.00
Stationery, printing and supplies	600.00	955.82	980.00
Subscriptions and dues	320.00	320.70	320.00
Taxes—social security, etc	350.00	263.66	440.00
Telephone and cable	800.00	879.99	1,000.00
Travel	120.00	58.66	410.00
Bylaws—printing and attorney's fees	100.00	—	200.00
Furniture and fixtures	1,250.00	228.04	260.00
Public relations program—see Schedule III	—	—	8,250.00
Woman's Auxiliary	—	—	2,750.00
Total Budgeted Expenses	$29,850.00	$27,292.23	$41,850.00
Special Authorized Expenses			
Hugh Lytle's Survey	1,000.00	1,000.00	—
Dr. S. Yamauchi's trip to Aging Conference	645.00	645.00	—
Total Expenses	$31,495.00	$28,937.23	$41,850.00
Less JOURNAL expenses reimbursed	5,650.00	5,221.92	6,620.00
	$25,845.00	$23,715.31	$35,230.00
EXCESS OF INCOME OVER EXPENSE	(735.00)	1,928.35	—

The figures set forth in the budget in some instances do not coincide with the auditor's figures inasmuch as the auditor's report is not broken down in the same categories as the budget report. The total differences are minor. For instance, for 1960 the auditor reports $211.54 more income and $446.72 less expenses than are listed in the 1960 column of the budget.

Following the system instituted in 1959, the HAWAII MEDICAL JOURNAL expenses were kept separate and the prorated expenses reimbursed to the Association. The deficit for 1961 is predicated on the sharp curtailment of pharmaceutical advertising. Since the budget was prepared there are indications that the advertising might pick up some and the deficit decreased accordingly. It should be noted that the deficit is merely an arbitrary paper figure and does not represent an actual loss.

JOURNAL BUDGET

	1960 BUDGET	1960 ACTUAL	1961 BUDGET
INCOME			
Advertising	$31,000.00	$31,022.47	$21,750.00
Sales and subscriptions	4,000.00	4,134.75	4,450.00
Total income	$35,000.00	$35,157.22	$26,200.00
EXPENSES			
Auto allowance	$ 300.00	$ 300.00	$ 300.00
Commissions paid	700.00	669.71	680.00
Discounts allowed	2,500.00	2,691.53	1,500.00
Miscellaneous	40.00	1.23	10.00
Postage	250.00	301.40	300.00
Printing	24,000.00	24,548.50	18,500.00
Rent	920.00	924.00	920.00
Salaries	4,000.00	3,649.67	5,000.00
Stationery and supplies	200.00	24.02	50.00
Telephone	250.00	245.77	250.00
Taxes	100.00	108.25	150.00
Translations	30.00	16.00	—
Copyrights	—	48.00	30.00
Total expenses	$33,290.00	$33,528.08	$27,690.00
EXCESS OF INCOME OVER EXPENSE	$ 1,710.00	$ 1,629.14	($ 1,490.00)

The annual meeting income is predicated on a total registration of 215 doctors at $15.00 each plus 35 exhibitors. Since preparing the budget the Coca-Cola Bottling Company was approached and agreed to pay for a booth as well as distribute free Cokes to the doctors. In 1960 special promotion on the mainland produced 270 registrants, or 70 more than anticipated. Increased income from annual meetings is necessary to keep the Association from running in the red.

ANNUAL MEETING

	1960 BUDGET	1960 ACTUAL	1961 BUDGET
Registration	$1,050.00	$1,950.43	$2,605.00
Banquet	—	10.69	20.00
Breakfasts	—	117.75	—
Picnic	—	(10.64)	20.00
Exhibitors	2,100.00	2,097.66	2,175.00
	$3,150.00	$4,173.89	$4,870.00

The new public relations program has a budget of $8,250.00 based on a $15.00 assessment for 550 members, and is broken down as follows:

PUBLIC RELATIONS

	1961 BUDGET
INCOME	
Assessment	$8,250.00
EXPENSES	
Salary for Hugh Lytle	$5,000.00
Mr. Lytle's trip to PR conference	550.00
Mr. Lytle's MESA dues	10.00
Subscription to PR Magazine	25.00
Postage	300.00
Stationery and printing	600.00
Telephone and cable	180.00
Travel	190.00
Miscellaneous	1,395.00
Total expenses	$8,250.00

The Council has approved of the following recommendations and they are hereby submitted for confirmation by the House of Delegates:

(1) The JOURNAL subscription for 1962 be increased from $4.00 to $6.00 and when the next contracts with the Hawaii Nurses Association and the Hawaii Society of Medical Technologists are negotiated that they be given a 50% discount ($3.00).

(2) The annual dues for 1962 be increased from $40.00 to $60.00 to include $15.00 for the public relations program (raised in 1961 by assessment) and that charges for the public relations program be kept on a separate schedule.

(3) The consultant's fee for the public relations program for 1962 be set at $6,000.00 in accordance with the provision outlined at the time he was engaged.

(4) That dues in the amount of $2.00 be set for each inactive member for 1962 in order to cover the costs of keeping him on the roster.

It should be noted that the AMA delegates' expenses this

year are figured on the basis that they will travel tourist rather than first class and will receive per diem allowances rather than a set sum.

The bills for the Physician's Benevolent Fund were sent out in September and as of December 31, 1960, $3,875.00 was collected. Interest in the amount of $15.36 was earned, making a total of $3,890.36.

FREDERICK L. GILES, M.D.

Report of the Treasurer

Your reference committee recommends approval of the Treasurer's Report and moves the acceptance of the recommendations made in the report. Your committee recommends that the wording in the next to the last paragraph be changed as follows: "It should be noted that the AMA delegates' travel expenses will be reimbursed on the basis of tourist class rates insofar as possible, and that the delegates will receive per diem allowances rather than a set sum."

Your reference committee recommends that a vote of confidence be given to the Auditor, Mr. Hough, in recognition of the fine work he has done during the past several years.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

SECRETARY'S REPORT

The total membership of the Association, in all classes, as of December 31, 1960, was 619, of which 539 (18 more than reported December 31, 1959) were regular dues paying members. Life members and associate members increased by two each. The total number of physicians licensed to practice medicine in Hawaii as of December 13, 1960, was 883 (51 more than last reported) of which 662 (30 more than last reported) reside in Hawaii.

As of December 31, 1960, there were 503 active members of the American Medical Association, an increase of 36 over December 31, 1959.

There is still inconsistent membership reporting which it is hoped will be corrected by the proposed revision of the bylaws.

By counties the membership is made up as follows:

	REG.	LIFE	MIL.	HON.	ASSO.	RET.	TOTAL
Hawaii	45	4			2		51
Honolulu	448	23	1	8	36	3	519
Kauai	12			1			13
Maui	34	1	1				36
	539	28	2	9	38	3	619

The following is a summary of some of the more important actions taken by the Council during the three meetings it has held since the last annual meeting:

On August 16, 1960, the Council (1) authorized the President to sign a one-year extension of the Medicare contract with no changes; (2) approved the establishment of the Rehabilitation Project under the control of the Chronic Illness and Aging Committee.

On December 13, 1960, the Council (1) appropriated money to send a delegate to the White House Conference on Aging; (2) agreed to contribute prizes for both the Hawaiian Science Fair and the AAPS Essay Contest; (3) confirmed the appointment of Harry L. Arnold, Jr., to the University of Hawaii's Advisory Board to the Institute of Health Research; voted to present the public relations program to the individual counties for approval with the suggestion that the counties assess their members $15.00 each to cover expenses for 1961.

At its March 27, 1961, meeting the Council (1) asked the Advisory Committee to the Bureau of Crippled Children to re-evaluate its report regarding fees; (2) advised The Hawaii Aeronautics Commission that the Association had no objections to its dealing with doctors to rent space at the airport provided no percentage kick-back or free medical service is involved in the rental contract; (3) approved the principle of the Medic-Alert Foundation; (4) approved the Auditor's Report, the Treasurer's Report, and the budget; (5) instructed the Secretary to look into the manner of dues reporting; (6) voted to recommend to each county society that they write their local Social Security office to see if they will authorize a charge for filling out forms relating to disability; (7) proposed that the 1962 annual meeting be held May 3, 4, 5, and 6 on Maui; (8) approved the Department of Health's inviting the Federal Government to send out a venereal disease investigator; (9) agreed to waive the registration fees of Drs. Alvarez, Cline, and Arnold, Jr.; (10) accepted the Awards Committee's nomination for the Robins Award.

The date suggested for the next annual meeting, May 3-6, must be approved by the House of Delegates. I recommend that the House of Delegates confirm this date and grant the Council permission to change the time if such change should become necessary.

RODNEY T. WEST, M.D.

Report of the Secretary

Your reference committee approves the report of the Secretary and moves adoption of the date suggested for the next annual meeting, May 3-6, 1962.

ACTION:

The chairman moved adoption of this portion of the report.

Dr. Burden advised that the new Sheraton Hotel in Lahaina might be completed by June 1 and asked if the House wanted to take this into consideration in setting the date for the next annual meeting. Dr. Ando was asked to clarify this. He advised that the Council could change the dates of the meeting should it become necessary.

The report was adopted.

PUBLIC RELATIONS COMMITTEE

Since the PR Committee has existed officially for less than 90 days, this report will be a brief summary of the steps leading to its formation, major accomplishments to date, and a prognostication for the coming year:

September, 1960—*Initial survey* of the public relations needs of the Hawaii Medical Association completed by Special PR Fact-Finding Committee. Report and recommendations approved by HCMS Board of Governors and HMA Executive Council.

October, 1960—*Additional 30-day depth survey* and extension of initial work of PR Fact-Finding Committee completed by professional PR counselor, Hugh Lytle. Concise summaries circularized; full report on file.

November, 1960—*Lytle Report* and Recommended Program for Action approved by medical society officers. Retention of Mr. Lytle as PR counselor to the HMA and executive secretary of the proposed PR Committee on half-time basis for 1961 tentatively approved pending financing and official sanction by component societies.

December, 1960—*Means of financing* $8,000 first-year cost of PR program explored in several meetings with medical association officers. Suggested proposal: HMA to request each county society to assess its members $15 per capita to get program started in 1961. House of Delegates later to consider appropriate increase in state dues to perpetuate program beyond 1961. Request to be acted upon by all county societies at next meetings.

January, 1961—*Proposed organization*, functional plan, and goals of Public Relations Committee circularized to membership. Special PR educational program sparked by prize-winning TV film *Eye of the Beholder* presented at January HCMS membership meeting. Projected PR program, organization and $15 per capita assessment approved by all county societies in virtually unanimous vote. Mr. Hugh Lytle retained as PR counselor to HMA on half-time basis.

January-March, 1961—*During its first 90 days* the new PR Committee completed a total of 56 separate actions in accord with its over-all goal: "To create and maintain a more positive group image of the medical profession in the public mind . . ." The following are examples of accomplishments to date: (Detailed reports in PR Committee files.) Selection and appointment of 51 sub-committee members; 3 planning sessions; 16 policy decisions; 16 PR projects completed or under way; 23 additional projects pending, under study; 26

articles, releases to news media; 2 TV programs assisted, moderated; 6 TV programs planned for balance of 1961; 4 awards, contests; planned and publicized; Annual Legislative Dinner entertainment program; 43 medical speakers assigned to community educational projects; and 100+ questionnaires screened, rated in preparation for: Speakers Bureau being organized; consultative PR assistance to other key committees and medical association projects.

Prognostication: April, 1961—Now that the new HMA PR program has been approved and launched, continuing success will be contingent upon the following: (1) Formulation of sound policies at all levels. (2) Increased assistance from able and devoted physicians to PR counselor and committee chairmen. (3) Delegation of additional authority to PR sub-committee section heads and committee members. (4) Effective efforts to improve press-medical relationships. (5) Increasing use of new Speakers Bureau. (6) Permanent inclusion in HMA bylaws of provisions for a continuing PR program and adequate, increasing, financing annually incorporated in dues structure. (7) Enhancing the awareness of the membership of the increasingly vital role of good public relations in preserving the free enterprise system of medicine.

The Committee wishes to express its sincere gratitude for outstanding assistance given during the past months by Mr. Hugh Lytle, Miss Lee McCaslin, Mr. Richard Kennedy and his staff, and the officers of the state and county medical societies.

WILLIAM H. STEVENS, M.D.

Report of the Public Relations Committee

Your reference committee recommends approval of the report as it stands.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

P. R. COUNSEL'S REPORT

A detailed report has been filed by the chairman of the Public Relations Committee.

It should be added that the medical profession of Hawaii, in the space of a few months, has begun to take its rightful place as a forceful influence in the community.

Through the medium of the press, radio, and television it has helped enhance the image of the physician as a scientific humanitarian in numerous ways. Physicians always have had this role, but their story has not always been told. More and more, this picture should come into focus, without any violation of medical ethics. Good deeds can and must be reported.

By means of a minor reorganization your Public Relations Committee now can and does act swiftly when required. The profession acted fast to take the initiative in the matter of mass oral polio vaccination. It is conducting an educational campaign relative to the Stockton Plan. Its officers have acted fast on numerous other occasions. Examples are swift endorsement of a proposed law to ease tourist complaints about mainland prescriptions, and the current discussion with the State Department of Social Services concerning the possibility of plastic surgery as therapy for criminals.

An ill-considered attack on animal surgery by a neighbor island editor drew an immediate, reasoned reply from the Honolulu Society president. This was printed in full with excellent effect.

The Association and the County Societies are currently working with the Woman's Auxiliary, seeking public understanding of proposed laws dealing with medical care for the aged.

These are a few of the activities in which your Public Relations Committee has been increasingly busy.

It expects to be even busier in the future with the long-range program that is being developed. That program, however, would be handicapped without the attention of the individual physician for, it should be repeated, public relations begins in the office of the individual physician. And it's a continuing effort, not a one-shot proposition.

I am personally grateful for the warm kokua I have had from so many in the profession.

HUGH LYTLE

Report of the Public Relations Counsel

Your reference committee recommends approval of this report as it stands.

ACTION:

The chairman moved adoption of this portion of the report. It was adopted.

The chairman moved adoption of this report as a whole. It was adopted.

Dr. West called the Delegates' attention to the total amount of annual dues they had approved in adopting the Treasurer's Report. The dues for 1962 will be $60.00. It was noted that this increase is in lieu of a special assessment.

Dr. Cushnie called for new business. Dr. Waite asked if it were in order for the House to request the Secretary to provide the component societies with copies of the actions taken by this body. It was noted that this information is contained in the reference committee reports which the Delegates will take back to their county societies.

The slate of nominees was announced by the President, who then asked for nominations from the floor. It was noted that Dr. D. D. Kliewer plans to change his residence. Dr. Ohata proposed that Dr. Joseph E. Andrews be nominated for the position of Councilor from Maui. The nominations were closed and ballots cast. The Secretary announced that the following doctors had been elected:

Frederick L. Giles, M.D.....*President-Elect*
Thomas H. Richert, M.D.....*Treasurer*
Richard D. Moore, M.D.....*AMA Delegate*
George H. Mills, M.D.....*AMA Alternate Delegate*
William N. Bergin, M.D.....*Councilor from Hawaii*
Joseph E. Andrews, M.D.....*Councilor from Maui*

There being no further business, the meeting was adjourned at 2:45 P.M.

RODNEY T. WEST, M.D.
Secretary

GENERAL MEMBERSHIP MEETING

May 5, 1961 — 2:45 P.M.
Mabel Smyth Auditorium

The President called the general membership meeting to order and advised that the only item to be taken up was the adoption of the revised Charter and Bylaws as recommended by the House of Delegates. Approximately 31 members were present.

Dr. Burden said that he felt that anything as important as the approval of the Constitution and Bylaws should be decided at a meeting where there was a greater representation of the membership and suggested that action be delayed until the evening meeting.

The question of a quorum was raised and the parliamentarian advised that a quorum was present.

Dr. Nishigaya said he had felt that way too but after finding that this is a legally constituted meeting called by the President and that the provisions of the Bylaws relating to revision had been fulfilled, he had withdrawn his objections. He noted that the committee had worked on this revision for three years and each county representative had been kept informed of the changes. Also that part that might prove controversial would not go into effect until January 1, 1962.

ACTION:

Dr. Wade moved the approval of the revised Bylaws as corrected by the reference committee and adopted by the House of Delegates. Dr. Nishigaya amended the motion to include the provision that the Executive Secretary advise each member of the revision and ask that if anyone has any objections to any of the changes, that these objections be transmitted to the Council.

The amendment and the main motion were approved unanimously.

The meeting adjourned at 3:05 P.M.

RODNEY T. WEST, M.D.
Secretary

CHARTER AND BYLAWS OF HAWAII MEDICAL ASSOCIATION

(Revised May 5, 1961)

CHARTER OF INCORPORATION

ARTICLE I — Name

The corporation heretofore, on July 15th, 1856, duly incorporated by charter granted under the laws of the Kingdom of Hawaii under the name of "The Hawaiian Medical Society," and since 1941 as the "Hawaii Territorial Medical Association," is hereby continued and constituted in perpetuity as a body corporate under the name of "HAWAII MEDICAL ASSOCIATION" with all the rights, benefits, privileges and immunities which now are or hereafter may be secured by law to corporations of this character.

ARTICLE II — Office

The principal office of the corporation shall be at Honolulu, City and County of Honolulu, State of Hawaii, but the corporation shall have the power to establish and maintain such other offices within or without the State of Hawaii as may be deemed necessary or proper.

ARTICLE III — Purpose; Component Societies

The purposes of the corporation and the objects for which it is organized are, in addition to any others set forth elsewhere in this charter: To federate and bring into one compact organization the entire medical profession of the State of Hawaii and to unite with similar state medical societies to form the American Medical Association; to extend medical knowledge and advance medical science and to promote the betterment of public health; to elevate the standards of medical education, and to foster the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to guard and foster the legitimate interests of members of the medical profession and to protect them against imposition; to enlighten and direct public opinion in regard to the problems of medicine, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life; to charter or accredit as affiliates of the corporation, county or other subordinate medical societies or association (hereinafter referred to as "component societies"), whether incorporated or unincorporated, upon such lawful terms and conditions and with such rights and privileges in relation to this corporation as the bylaws shall provide and to such extent as shall not be prohibited by law.

ARTICLE IV — Membership

Membership in the corporation shall be limited to doctors of medicine. Additional qualifications for such membership may be provided in the bylaws of the corporation, and the manner of admission and expulsion of such members shall be as provided in the bylaws. Such bylaws, among other things, may provide for life, annual, guest, or other classes of membership, and for membership by reciprocity with other medical societies or associations, whether incorporated or unincorporated, and may require as a condition of membership in the corporation, that such members also be members of component societies.

ARTICLE V — Powers

The corporation hereby created shall have power to sue and be sued in any court; to make and use a common seal and alter the same at its pleasure; to maintain offices; to receive, hold, purchase, lease, sell and convey such real and personal property as may be required for the purposes of the corporation; to borrow money and to mortgage or otherwise hypothecate the property of the corporation to secure any of its debts; to appoint such subordinate officers and employees with such titles and with such powers, duties and functions as the business or purposes of the corporation may require; to make, amend and repeal bylaws not inconsistent herewith or with any laws for the management of its property; the admission and classification of members, the payment of entrance fees, dues, and assessments; the election, government and removal of its officers and the regulation of its affairs, and any other matters which may properly be regulated by bylaws under this charter or the laws of this State; and, in addition, shall have such other powers as shall be necessary, appropriate or incidental to the exercise of the objects and powers hereinabove enumerated and such other powers as shall be expressly given by law to corporations of this character. The bylaws, among other things, may require that any specified policies or measures or classes of policies or measures, in order to be adopted by this corporation, shall first be approved, or shall be consented to, by each component society or by the House of Delegates, and may provide for and regulate the attendance of delegates and members, and the voting by members, in person or by proxy.

ARTICLE VI — House of Delegates, Council and Officers

The corporate powers, business, and property of the corporation shall be exercised, conducted and controlled by a House of Delegates constituted as hereinafter set forth; provided, that when the House of Delegates is not in session, the Council (as hereinafter defined) shall have, exercise and perform all of the powers, duties, and functions of the House of Delegates, subject to any restrictions contained in the bylaws.

The House of Delegates shall consist of the President, the immediate Past President, the Vice Presidents, (including the President-elect), the Secretary and the Treasurer of the corporation, the elected councilors, and delegates elected by the component societies; each component society shall elect such number of such delegates and for such terms as shall be fixed or provided for in the bylaws.

The Council shall be composed of the President, the immediate Past President, the President-elect, the Secretary and the Treasurer of the corporation, and such number of additional Councilors as shall be provided in the bylaws. The President-elect, Secretary, Treasurer and other Councilors shall be elected by the House of Delegates. The Councilors, other than the President, President-elect, Secretary and Treasurer, shall be elected for such terms that, as nearly as practicable, the terms of not more than one-third of them shall expire during any one calendar year, and the bylaws shall so provide. The Council shall constitute the finance committee of the House of Delegates and shall perform such other duties as shall be prescribed by this charter or the bylaws.

The officers of the corporation shall be the said President, President-elect, Secretary, Treasurer and other members of the House of Delegates, the Councilors, one or more Vice-Presidents, and such other officers as shall be provided for in the bylaws. The terms of all officers shall be as provided in the bylaws, but all officers shall hold office until their successors are elected and take office, unless sooner removed. The House of Delegates by vote of at least two-thirds of all of the members to which it is then entitled may suspend or expel any Delegate, and may suspend or remove any President, President-elect, Secretary, Treasurer, or other member of the Council. This function may never be exercised by the Council. Any other officer or employee of the corporation may be elected, suspended or removed by the House of Delegates (or when it is not in session, by the Council) unless

it is otherwise provided in the bylaws. In the absence or disability of the President, the President-elect, and after him any Vice-President, in the order of priority or under such conditions as shall be prescribed in the bylaws, may perform the duties of the President. The duties of all officers and employees of the corporation, in addition to those prescribed by this charter, shall be prescribed in the bylaws. All members of the House of Delegates and all other officers shall be residents of the State of Hawaii, except as may be otherwise provided in the bylaws in conformity with the laws of this State, and the names and places of residence of all such officers shall be registered in the office of the Treasurer of the State of Hawaii from time to time upon their election or appointment.

ARTICLE VII — Filing of Bylaws

A copy of all rules, regulations and bylaws of the corporation and of all amendments thereof shall be filed with the Treasurer of said State within fourteen days after the adoption thereof.

ARTICLE VIII — Non-stock Corporation

The corporation is not organized for profit and it shall not issue certificates of stock or other evidence of ownership of its property, and no part of its assets, income or earnings shall be used for dividends, or otherwise withdrawn or distributed to any of its members, except upon liquidation of its property in case of corporate dissolution; but it may issue such evidences of membership, life, annual or otherwise, as it may deem proper and appropriate.

ARTICLE IX — Limited Liability

The property of the corporation shall alone be liable for the payment of its debts and liabilities, and no member of the corporation shall be liable for any of such debts and liabilities beyond the unpaid amounts, if any, which may be owing from him to the corporation for any fees, dues or assessments theretofore validly levied or assessed against him pursuant to this charter and the bylaws of the corporation.

ARTICLE X — Law Applicable

This charter and the corporation hereby created shall be subject to all existing laws and to all laws, whether amendatory, repealing or otherwise, that may hereafter be enacted and applicable to charters and corporations of this character.

ARTICLE XI — Amendments

This charter may be amended at any time by vote of a majority of all the members present and voting at a meeting duly called and held for that purpose, and subject to compliance with all applicable provisions of law.

BYLAWS OF HAWAII MEDICAL ASSOCIATION

CHAPTER I — Name and Component Societies

Section 1. The name of the organization shall be the Hawaii Medical Association.

Section 2. The Hawaii County Medical Society, the Honolulu County Medical Society, the Kauai County Medical Society, and the Maui County Medical Society, and also such county medical societies as may be granted charters in the future, shall constitute the Hawaii Medical Association. Those physicians who are practicing in counties where there is no county medical society may apply for membership in a nearby or adjacent county medical society.

Section 3. Only one component medical society shall be chartered in any one county of the State.

Section 4. Charters shall be issued by the House of Delegates, and shall be signed by the President and the Secretary. The House of Delegates may revoke the charter of any component society whose actions are in conflict with these bylaws, at a regular or special session of the House of Delegates, provided that such action shall not be voted on by the delegates elected by the county whose charter's revocation is being considered. Revocation of a component society's charter shall be made effective upon a motion carried by three-quarters of the members of the House of Delegates present and eligible to vote.

Section 5. Each component society shall adopt and maintain a charter of incorporation, or a constitution and bylaws, which shall not be in conflict with the charter and bylaws of the American Medical Association and this Association, or both. The terms and provisions of these bylaws shall control and govern such component society, the officers, and members thereof, and the constitution or bylaws of the component society shall not be amended in any way to conflict or be inconsistent with the constitution and bylaws of this Association.

Section 6. Duties of the component societies. (a) Each component society shall have general direction of the affairs of the profession in its jurisdiction, and shall discipline its members if they violate the Medical Practice Act of the State or the Principles of Medical Ethics of the American Medical Association or of this Association, and for such other causes as may be provided in the charter, constitution or bylaws of said component society. (b) Each component society shall keep a roster of its members, and of the non-affiliated licensed physicians of its jurisdiction, recording the full name, address, medical school, and date of graduation, date of license to practice in the State, and such other information as may be deemed pertinent. (c) The Secretary of each component society shall transmit to the Association, on the first of each month, (1) a list of the changes that have been made in its roster and (2) minutes of all county society meetings. (d) The secretary of each component society shall send to the Secretary of the Association, within thirty (30) days after the annual meeting of his society, (1) a list of its delegates and alternate delegates, (2) a roster of its officers and members, (3) a list of non-affiliated licensed physicians in its jurisdiction. (e) Each component society shall be responsible for collecting from its members such dues and assessments as the House of Delegates has levied against such members, and shall immediately remit same to the Treasurer. (f) The Treasurer of each component society shall collect from its members the American Medical Association dues, which are to be sent immediately to the Association for transmittal to the American Medical Association.

Section 7. Powers of the component societies. (a) A component society shall have the following powers: (1) to elect its members in conformity with its bylaws, (2) to make rules and regulations not in conflict with these bylaws, (3) to provide for its financial support, (4) to adopt principles of ethics not in conflict with the Principles of Ethics of the American Medical Association or this Association, (5) to govern the professional conduct of its members, and (6) to discipline its members.

CHAPTER II — Membership

Section 1. Every doctor of medicine licensed to practice medicine and surgery or in postgraduate training in the State of Hawaii, who is a member in good standing of a component society, shall be a member of this Association and the American Medical Association, either as an active or inactive member.* Each component society shall judge the qualifications of its members.

Section 2. Each member must adhere to the Principles of Medical Ethics of the American Medical Association and to such Principles of Ethics as may from time to time be adopted by this Association.

Section 3. Honorary Members. The Association may by action of the Council and the House of Delegates grant Honorary Membership to eminent physicians from outside the State of Hawaii.

Section 4. Active Members. Active membership shall be limited to those members of component societies who are entitled to exercise the rights of membership in their component societies, including the right to vote.

Section 5. Inactive Members. Inactive membership shall be limited to those members of the component societies who are ineligible for active membership in the component so-

* Effective January 1, 1962.

cieties. The eligibility of such members shall be reviewed annually.

Section 6. (a) A member shall hold only one type of membership in the Hawaii Medical Association at any one time. (b) The Secretary of the Hawaii Medical Association shall be officially informed if an active or inactive member is not in good standing, by the Secretary of the component society. The action shall automatically remove the name of that member from the membership roll and shall be reported to the Council. (c) No active member of this Association may be an active member of any other constituent association of the American Medical Association.

Section 7. (a) All members of the Association may attend the scientific meetings of the Association, upon proper registration of their attendance, but only the active members may vote or hold office or serve on committees of the Association. (b) Any person whose name has been dropped from the membership roll of a component society shall not be entitled to any of the privileges or benefits of membership, nor shall he be permitted to take part in any of the Association's proceedings. (c) All active and inactive members of this Association shall subscribe to the Hawaii Medical Journal. (d) All members of this Association shall be either active or associate members of the American Medical Association. The Secretary of this Association shall certify the members for enrollment in the American Medical Association.

Section 8. Transfer of Membership. (a) A member who moves his professional activities, from the county of the component society which he holds membership in this Association to another county in which there is a component society, is eligible to membership in the component society of the new location on the presentation of a transfer card, and satisfactory evidence that his dues have been paid in full in the component society in which he holds membership; provided, however, that he must be elected to such membership. (b) He shall forfeit his membership in this Association at the end of the fiscal year in which such change of location of practice occurs, unless after proper application he is elected to membership in the society of the county to which he has moved. (c) When a member in good standing in a component society moves to another county or another jurisdiction in this State he shall, on request for transfer and resignation from the component society, be given a transfer card, without cost. He must assume such finanical obligations as shall be deemed proper by the component society to which he is transferred and to which he makes application for membership by transfer. (d) A transfer from another state shall meet all the qualifications for membership in the component society into whose jurisdiction he moves.

Section 9. Disciplinary Action. (a) Any member of the Association who may feel aggrieved by the action of a component society in its disciplinary action of censure, suspension, or expulsion shall have the right to appeal to the Council of the Association on questions of procedure and privileges of membership. (b) The appeal shall be perfected within thirty days following date of decision by the component society in question. (c) In addition to such disciplinary action as may be taken by the component society under its constitution and bylaws, the Council of this Association after investigation and due notice may make a recommendation to the House of Delegates at a special or regular meeting that it censure, suspend, or expel any member for an infraction of these Bylaws or violations of the Principles of Medical Ethics of the American Medical Association.

In hearing appeals the Council of this Association shall review all questions and procedures, and may in its discretion review the evidence contained in the records of the original proceedings held before the disciplinary body of the component society. The Council of this Association may make findings of fact contrary to or in addition to those made by said component society. Such findings may be based on the evidence adduced before the disciplinary committee of the component society or upon such evidence together with such evidence if any presented to or by the Council of this Association. The Council of this Association shall use any lawful means which in its judgment will best and most fairly present all the facts involved. The Council of this Association may, for the purpose of making such findings, or for other purposes in the interest of justice, take additional evidence of or concerning facts material to the questions involved, or may for such purpose appoint a committee of its own members, or any notary public, to act as referee for the taking of such evidence. The Council of this Association may affirm, reverse, or modify the decision of the component society or make such other disposition of the proceedings as it may deem proper.

The decision of the Council of the Association shall be final and binding upon the component society and the member of the component society, except that the member or the component society shall have recourse to the American Medical Association as provided for in that Association's bylaws.

CHAPTER III — Officers, Councilors, and House of Delegates

Section 1. The officers of the Association shall be the President, President-elect, one or more Vice-Presidents, the Secretary, the Treasurer, and the immediate Past President. There shall be six Councilors who, together with the President, President-elect, Secretary, Treasurer, and immediate Past President of the Association, shall constitute and shall be known as the Council.

Section 2. Election. The officers, councilors, and delegates to the American Medical Association shall be nominated and elected from among members in good standing as the final order of business of the last scheduled session of the Annual Meeting of the House of Delegates.

Section 3. The President, the President-elect, the Secretary, and the Treasurer shall be elected to hold office until their successors have been duly chosen, unless sooner removed. The President and the President-elect shall be elected for a period of one year. The Secretary and the Treasurer shall be elected for a period of two years and shall be elected in alternate years. Two members of the Council shall be elected annually for a term of three years. In the event of a vacancy, a councilor shall be elected for the unexpired term. Delegates and alternate Delegates to the American Medical Association shall be elected for a term of two years in the calendar year preceding the meeting of the House of Delegates of the American Medical Association to which they are elected, in accordance with the constitution and bylaws of that Association. Delegates and representatives of this Association to other state and national bodies may be elected as the interests of this Association may require, and credentials shall be issued to all such delegates and representatives, signed by the President and the Secretary.

Section 4. Each component society shall be entitled to send to the House of Delegates of this Association one delegate or his alternate for every twenty-five active members, and one for every fraction thereof, except that each component society which has otherwise complied with the requirements set in these Bylaws shall be entitled to at least one delegate. At a meeting prior to the Annual Session, each component society shall elect such delegates and alternates to serve for a term of not less than two years.

Section 5. Duties of Officers. (a) *President.* The President shall (1) preside at all meetings of the Association, (2) appoint all committees, (3) be a member *ex officio* of all committees except the nominating committee, (4) deliver an address at the Annual Meeting, (5) visit the various component societies of the State during his term of office, (6) perform such other duties as custom and parliamentary practice may require, and (7) attend the annual meeting of the House of Delegates of the American Medical Association. (b) *President-elect.* The President-elect shall (1) become President at the termination of the President of his office as President-elect, (2) perform the duties of the President in the absence of the President and perform such duties as may be required by the President, (3) be a member of the House of Delegates and the Council and *ex officio* of every committee except the nominating committee. In the event of the President's death, resignation, removal, incapacity, or in the judgment of the Council, the President's refusal to act, the President-elect shall succeed him and shall

serve the remainder of the term of his immediate predecessor. If the term so served as President is less than six months, he shall also serve as Presdient until the second annual session following his original election as President-elect. If this President-elect succeeds to the presidency six months or more before the following annual meeting, the House of Delegates at that following session shall select another eligible person to serve as President. If the President-elect dies, resigns, is removed, or is unable to or, in the judgment of the Council, refuses to act, or if he succeeds to the presidency, the office of President-elect shall remain vacant, and at the next annual session, the House of Delegates shall elect an eligible person to serve as President until the next annual session. (4) In case of vacancy in the offices of both President and President-elect the Council shall appoint from one of its members the Acting President who shall serve until a President is elected at the next annual session of the House of Delegates. (c) *Treasurer.* The Treasurer shall (1) demand and receive all funds due the Association, together with bequests and donations, (2) make such payments as are duly authorized, (3) keep an accurate account of all money received and expended, supported by vouchers, (4) render to the Council before each Annual Session a statement of accounts together with a budget for the coming year, (5) at the expense of the Association give a bond in the sum of $2,500 for the faithful performance of his duties, (6) subject his accounts to audit by the certified public accountant appointed by the Council, (7) present the auditor's report together with the Treasurer's final report to the House of Delegates for examination at their annual session, and (8) be a voting member of the Council and of the House of Delegates. (9) If a vacancy in the office of the Treasurer occurs, the Council shall appoint an acting Treasurer to serve until the next Annual Session. (d) *Secretary.* The Secretary shall (1) keep either personally or through the assistance of the executive secretary the minutes of all the proceedings of the House of Delegates, the Council, and such other meetings as the President may direct, (2) be custodian of all records, books, and papers belonging to the Association except such as properly belong to the Treasurer, (3) keep account of and promptly turn over to the Treasurer all funds of the Association which come to his hands, (4) provide for the registration of members and delegates at the Annual Meeting, (5) keep a register of the members of the Association by counties and a roster of nonaffiliated licensed physicians in the State of Hawaii, (6) conduct the official correspondence of the Association, (7) notify members of meetings, officers of election, and committees of their appointment and duties, (8) employ such assistants as may be ordered by the House of Delegates and make an annual report to the House of Delegates, (9) supply all component societies with the necessary blanks for making their annual reports, (10) prepare and issue all programs in cooperation with the Scientific Program Committee, (11) file in the Office of the Treasure of the State of Hawaii the names and places of residence of all officers of the Association from time to time upon their election or appointment and a copy of the Bylaws of the Association and of all amendments thereto within fourteen days after the adoption thereof, and (12) be a voting member of the Council and the House of Delegates. (13) If a vacancy of the office of Secretary occurs, the Council shall appoint an acting Secretary to serve until the next Annual Session.

Section 6. The President, the President-elect, the Secretary, and the Treasurer shall be *ex officio* members of the Council and of the House of Delegates. Each shall have a vote in these bodies and shall be counted in determining a quorum.

CHAPTER IV — House of Delegates

Section 1. Election and Tenure of Office. (a) The House of Delegates shall consist of: (1) delegates or their alternates elected by the membership of the component societies in the ratio of one delegate and one alternate delegate for every twenty-five active members and one for each fraction thereof, except that each county society shall have at least one elected delegate, (2) the President, the President-elect, the Secretary, the Treasurer elected by the House of Delegates as herein above provided, (3) the immediate Past President, (4) the President of each county society, and, (5) the six elected councilors. (b) At a meeting prior to the annual meeting each component society shall elect such delegates and alternate delegates to serve for a period of not less than two years. (c) The number of delegates each county society is entitled to shall be determined by the number of active members on the roster of the county society as of December 31 of the previous year. (d) The secretary of each component society shall send to the Secretary of the Association not later than thirty days after its annual meeting and at least sixty days before the Annual Session of the Association: (1) a list of delegates and alternate delegates, (2) a roster of its officers and active members and inactive members, and (3) a list of the nonaffiliated licensed physicians within its jurisdiction. (e) All members of the House of Delegates shall hold their offices until their elected successors are certified by the Secretary of the Association at the Annual Meeting.

Section 2. Eligibility and qualifications of delegates of the House of Delegates. (a) At least three consecutive years' active membership in good standing in the delegate's component society immediately preceding election shall be required for election as Delegate or Alternate Delegate to the Association.

Section 3. Sessions and Meetings. (a) In each year there shall be one regular session of the House of Delegates which shall be held in April or May unless otherwise determined by the Council, and this session shall be designated as the Annual Session. (b) During any meeting of the Annual Session, the House of Delegates may elect to hold an interim session in the last six months of the same calendar year. The time and place of such interim session shall be determined by the Council as far as possible in advance and notice thereof published in the Journal of the Association. (c) In addition to the Annual and Interim Sessions, special meetings of the House of Delegates may be called by the President with the consent of the majority of all the Council members, or by written call stating the object of the meeting, filed with the Secretary in the office of the Association and signed by one-half or more of the members of the House of Delegates. Upon the filing of such call the Secretary shall within fifteen days thereafter fix the time and place for the holding of such special meeting and cause fitting notice thereof, stating the object of the meeting, to be sent by United States mail, postage fully prepaid, to each member of the House of Delegates, at least seven days prior to the date of the meeting.

Section 4. Credentials. (a) Delegates or Alternates shall present their credentials to the Secretary of the Association and be identified. (b) A duly elected Alternate Delegate designated by the President of his component society may be seated in the place of each absent delegate from the same component society. (c) If a Delegate, once seated, is unable to be present on account of sickness or any other emergency, his place may be taken by an alternate. (d) After an Alternate Delegate has been seated, he cannot be replaced. (e) A Delegate whose name has been placed on the roll of the House shall remain a Delegate until final adjournment of that session except as provided in (c) of this section.

Section 5. Quorum. (a) A majority of the authorized membership of the House of Delegates shall constitute a quorum. (b) Proxies shall not be recognized. (c) All meetings of the House of Delegates shall be open to the members of the Association. (d) The privilege of the floor will be confined to members of the House of Delegates and Past Presidents of the Association, except that the House of Delegates may in any session, by a two thirds (⅔) vote of its membership, extend an invitation to address the House to any person who in its judgment might assist in its deliberation.

Section 6. Reference Committees. (a) Prior to or at the commencement of each Annual Session the President shall appoint from the delegates thereto the proper number of reference committees to expedite the business to be transacted. (b) Each Reference Committee shall consist of not less than three members, including the chairman. (c) The Chairman of each Reference Committee shall be designated by the President. (d) The Reference Committees shall serve only during the session in which they are appointed. (e) References, resolutions, measures, propositions, committee

reports presented to the House of Delegates shall be referred to the appropriate reference committee for recommendation and report. (f) The reports of the Reference Committees shall be presented to the House before final action may be taken, unless otherwise provided in these Bylaws or unless unanimously otherwise ordered by the House of Delegates. (g) A member of a Reference Committee wishing to make a minority report must refrain from signing the majority committee report and must make his intention known to the other members of the Reference Committee while it is in executive session and prior to the presentation of the majority report to the House of Delegates. (h) Each Reference Committee shall convene whenever necessary, at the call of its chairman. It shall consider business referred to it and shall report to the House of Delegates when called on by the President or the chairman. (1) A majority of the members of each Reference Committee shall constitute a quorum. (j) A Reference Committee may summon officers, members of the Council, employees of the Association and others for such information as may be needed to formulate their conclusions and recommendations.

Section 7. Order of Business. (a) The following shall be the order of business at the sessions of the House of Delegates: (1) calling the meeting to order, (2) certification and seating of Delegates, (3) approval of the minutes of the previous meeting, (4) report of the President, (5) report of the Secretary, (6) Report of the Treasurer, (7) report of the component societies, (8) reports of the standing and special committees, (9) reading of the resolutions, (10) the appointment by the President of the Reference Committees, (11) recess and deliberation of the Reference Committees, (12) reconvening of the House of Delegates for receiving reports of the Reference Committees, (13) unfinished business, (14) new business that is received with the unanimous consent of the House of Delegates, (15) the election, (16) recess, (17) the call to order, (18) the presidential address, (19) installation of all new officers of the Association, (20) remarks by the newly installed President, and (21) adjournment.

Section 8. Functions and Duties of the House of Delegates. (a) The corporate powers, business, and property of the Association shall be exercised, conducted, and controlled by the House of Delegates. (b) It may issue charters to component societies. (c) It shall have power to revoke charters of component societies. (d) It may levy assessments in conformity with Chapter IX Section (3) of these Bylaws. (3) It shall approve all memorials and resolutions issued in the name of the Association before they shall become effective and be publicized. (f) It shall have authority to appoint committees for special purposes. Such committees shall report of the House of Delegates and may be present and participate in the debate on their reports when they are considered by the Reference Committees. (g) It shall order a special committee discharged or shall require that a special committee continue in status quo as it sees fit. (h) It shall elect Delegates and Alternate Delegates to the House of Delegates of the American Medical Association in accordance with the constitution and bylaws of that body. (i) At its annual session it shall set the time and place for any proposed interim or the next annual session, subject to revision by the Council. (j) It shall encourage postgraduate and research work. (k) All questions of an ethical nature brought before the House of Delegates shall be referred to the Council without discussion. (1) When a general referendum on any question pending before the House of Delegates is ordered by two-thirds of the members present and voting at the session of the House of Delegates, the Secretary shall submit such question to the entire membership, who may vote by mail or in person. If the members voting by mail shall comprise a majority of all the members of the Association, the majority of such votes shall determine the question and be binding on the House of Delegates, the Council, and the Officers.

CHAPTER V — The Council

Section 1. (a) The Council shall be the executive and administrative body of the Association while the House of Delegates is not in session. (b) Its resolutions and actions shall be decisive and final except that all resolutions and actions of the Council shall be subject to review and action by the House of Delegates. (c) Its actions shall be governed by the Charter and Bylaws of the Association, and the rules and regulations of the House of Delegates. (d) The Council shall have power and authority to employ, discharge, and arrange duties and fix compensation of and for any employee whom it may find necessary for conducting the affairs of the Association. (e) The Council shall consist of six councilors and the President, the immediate Past President, the President-elect, the Secretary, and the Treasurer. (f) Each county shall have at least one representative on the Council. (g) The Councilors shall be *ex officio* members of the House of Delegates.

Section 2. Election and Tenure of Office. (a) The Councilors other than the President, the President-elect, the immediate Past President, the Secretary, and the Treasurer shall serve for a period of three years, two being elected annually by the House of Delegates. (b) Councilors shall hold office until their successors are elected and installed, unless sooner removed. (c) No Councilor shall serve for more than two consecutive terms. (d) No Councilor shall serve as an elected delegate to the Association during his term as Councilor.

Section 3. Functions. (a) The Council shall serve as the executive body of the Association between sessions of the House of Delegates, as the Board of Censors of the Association, and as the Finance Committee, and shall carry out such other functions as may be delegated to it by the House of Delegates. (b) As the executive body, it shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association and shall have authority to appoint an editor and such assistants as it deems necessary. (c) In consideration of the Hawaii Medical Library's service to the members of the Association, it shall assist in the financial support of the Hawaii Medical Library and shall from time to time, and at least once a year, appropriate funds for this purpose, subject to the approval of the House of Delegates. In consideration of this financial support the library shall be at the service of any member of the Association. (d) As the Board of Censors, it shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to the Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Council without discussion. It shall hear appeals and decide all questions of discipline affecting the conduct of members of component societies and shall report its findings and recommendation to the component society. (e) In hearing appeals affecting members of component societies the Council may hear such additional oral or written evidence as in its judgment will best and most fairly present the facts. (f) As the Finance Committee it shall order an annual audit of the accounts of the Treasurer and other agents of the Association and present a statement of the same, together with a budget for the coming year, in its annual report made by the Treasurer to the House of Delegates. All monies received by the Council and its agents, resulting from the discharge of duties assigned to them, must be paid to the Treasurer.

Section 4. Meetings. (a) The Council shall hold its meettings at regular intervals at times and places that shall be fixed by the President. (b) Any four members of the Council may require the President to call a meeting for such time and place as shall be designated by them in writing. (c) members must receive at least three days notice by letter or telegram from the Association's office.

Section 5. Quorum. (a) A quorum shall consist of seven members of the Council. In the event of the inability of any Councilor to attend a meeting of the Council, the President of the Association, with the advice of the President of the component society concerned, may appoint an alternate in his stead from among the members of the component society.

Section 6. Duties. (a) The duties of the Council shall also include the study and supervision of the following activities: (1) all scientific work presented at each annual meeting, (2) scientific exhibits, (3) medical education and postgraduate education, (4) journal management and publica-

tion, (5) medical or related research, (6) arrangements for Annual Session, (7) preventive medicine and public health, (8) legislation, (9) economics, (10) workmen's compensation, (11) public relations, (12) cooperative relations with Federal and State Governments, foundations, and other lay groups, (13) medical care insurance, and (14) any activities not otherwise provided for; and finally, (15) the Council shall also keep constantly advised of, and collaborate with, the Health and Welfare departments of the State and with hospitals, clinics, and welfare agencies in furthering the health of the residents of the State.

Section 7. Order of Business. (a) The following shall be the order of business at meetings of the Council: (1) calling the meeting to order, (2) roll call, (3) approval of the minutes, (4) communications not requiring action, (5) communications requiring action, (6) report of the Secretary, (7) report of the Treasurer, (8) reports of standing and special committees, (9) unfinished business, (10) new business, and (11) adjournment.

CHAPTER VI — Sessions and Meetings of the Association

Section 1. Annual Session. (a) In each year there shall be an Annual Session which shall consist of (1) a general membership meeting, (2) a scientific meeting, and (3) a meeting of the House of Delegates. The following events if scheduled during the Annual Session shall become a part of the proceedings of that session (1) banquet, (2) picnic, (3) sports tournaments, (4) hobby, scientific, and commercial exhibits.

Section 2. General Membership Meeting. A general membership meeting may be called at any time in conformity with the provisions set forth in Chapter IV, Section 8 (1). (b) The order of business for the general membership meeting shall include (1) the call to order by the President or presiding officer, (2) the welcoming address by the Chairman of the Arrangements Committee, (3) the announcement of the time and place of the meeting of the House of Delegates, (4) such business as has been properly referred to the general membership for action. (c) The President, or presiding officer, shall adjourn or recess the general membership meeting before the scientific meeting convenes. The President with the consent of the Council or House of Delegates may call the general membership meeting at any time.

Section 3. Scientific Meeting. (a) The scientific meeting of the Association shall be established to foster the presentation and discussion of subjects pertaining to the advancement of the art and science of medicine and shall be presided over by the chairman of the Scientific Program Committee.

Section 4. House of Delegates Meeting. (a) The House of Delegates shall meet during the Annual Session and may also meet at any other time of the year as provided by Chapter 4, Section 3 of these Bylaws. (b) It may recess and reconvene from time to time as may be necessary to complete its business, provided that the hour shall conflict as little as possible with the general membership or scientific meeting. (c) It shall not adjourn until after the business referred to the General Membership has been acted upon by the general membership.

Section 5. Attendance at the Annual Session. (a) Each member in attendance at the Annual Session shall enter his name on a registration form, indicating the component society of which he is a member. When his right to membership has been verified and he has paid his registration fee, he shall receive a badge. (b) No member shall take part in any of the proceedings of the Annual Session until he has complied with the provisions of this section. (c) The Secretary of the Association may issue a guest card to (1) a reputable physician not eligible for membership, upon payment of a registration fee which shall be designated by the Council, (2) interns and residents, (3) members of allied professions not eligible to membership, (4) physicians who under certain circumstances have had their registration fee waived by the Council. This card shall be held only for the Annual Session for which it is issued and shall not entitle the holder to attend any meetings of the House of Delegates.

Section 6. Quorum. (a) The quorum for the meetings of the House of Delegates to transact the business of the House shall be a majority of the authorized membership of the House of Delegates. (b) The quorum for the General Membership Meetings to transact the business properly referred to them shall be one member more than the majority of the authorized membership of the House of Delegates. (c) The quorum for the meetings of the Council shall be seven members of the Council. (d) Proxies shall not be recognized for determining a quorum nor for the transaction of business.

CHAPTER VII — Election and Installation of Officers, Delegates, and Councilors

Section 1. Eligibility for Election to Office. (a) Any active member shall be eligible for election or appointment to any office of this Association if he is an active member in good standing at the time of election and has been an active member of this Association for at least three consecutive years immediately preceding his election or appointment.

Section 2. Nominations. (a) Nominations shall be made by the nominating committee. (b) Any delegate to the Annual Session of the Association shall be eligible to make nominations from the floor.

Section 3. Elections. (a) The Officers of the Association, the Delegates and Alternate Delegates to the AMA, and the Councilors, shall be elected by the House of Delegates, and a majority of the votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the votes cast, the nominee receiving the lowest number of votes shall be eliminated from consideration in a new ballot taken. This procedure shall continue until one of the nominees receives a majority of the votes cast. When there is only one nominee for an office, it shall be the duty of the Secretary to cast the elective ballot of the House of Delegates for the nominee. (b) Election shall be by ballot. (c) Whenever possible the election shall be the last order of business of the last meeting of the Annual Session of the House of Delegates.

Section 4. Installation. (a) The Officers and Councilors elected at the Annual Session shall be installed at the annual meeting and shall assume office immediately following the adjournment of the Annual Session. (b) The Delegates and Alternate Delegates to the American Medical Association shall assume their duties in accordance with the constitution and bylaws of that organization.

CHAPTER VIII — Committees

Section 1. Standing Committees. (a) The committees of the Association shall include: (1) a Scientific Program Committee, (2) a Legislative Committee, (3) a Committee on Arrangements, (4) a Cancer Committee, (5) a Diabetes Committee, (6) a Health Education Committee, (7) a Public Relations Committee, (8) a Nominating Committee, (9) American Medical Education Foundation Committee, (10) a Bylaws and Parliamentary Committee, (11) an Awards Committee, (12) a Chronic Illness and Aging Committee, (12) an Emergency Medical Service Committee, (13) a Federal Medical Services Committee, (14) a Hospital Committee, (15) a Heart Committee, (16) a Mental Health Committee, (17) a Polio Committee, (18) a School Health Committee, (19) a Maternal and Infant Mortality Study Committee, which shall act as the Advisory Committee to the Bureau of Maternal and Child Health, (20) such other committees as the President may deem necessary.

Section 2. Advisory Committees. The advisory committees shall include committees on (1) Crippled Children, (2) Tuberculosis, (3) Venereal Disease, (4) Heart Disease, (5) Radium, (6) Woman's Auxiliary, and (7) such other committees as the President may deem necessary.

Section 3. Appointment of Committees. The President shall appoint all standing committees and advisory committees of the Association and designate the chairmen. He shall have a list of the appointments circulated to the membership.

Section 4. The Legislative Committee shall consist of at least five members in addition to the following *ex officio:* the President, the immediate Past President, the President-elect, the Vice-Presidents, and the chairmen of the Legislative Committees of the component societies. It shall represent the Association in securing and enforcing legislation in the

interest of public health and advancement in the standards of medical practice. It shall keep in touch with professional and public opinion, and shall endeavor to shape legislation so as to secure the best results for the whole community.

Section 5. The Committee on Arrangements shall be composed of members from the component society of the county in which the Annual Session is to be held. The chairman of the Scientific Program Committee and the Secretary shall be *ex officio* members of this committee. It shall provide suitable accommodations for the meeting places of the Association, of the House of Delegates, and of their respective committees, and shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Secretary for publication in the program, and shall make additional announcements during the session as occasion may require.

Section 6. Special Committees. (a) The special committees of this Association may be created by the President for the purpose of performing any special duty not otherwise assigned to a standing committee and shall remain in office until their function has been performed or until ordered disbanded by the House of Delegates. (b) The chairmen and members of the standing and special committees who are not members of the House of Delegates of the Hawaii Medical Association shall have the right to present the reports of their committees in person to the Reference Committees of the House and to participate in the debates.

CHAPTER IX — Funds and Expenses

Section 1. Membership Dues. (a) The annual dues of the Association and the fee for the support of the HAWAII MEDICAL JOURNAL shall be recommended for the Council of the Association at its final meeting prior to the Annual Session and shall be subject to ratification or amendment by the House of Delegates of the Association. The Council, with the approval of the House of Delegates, may levy special assessments. Each member shall pay the prescribed annual dues and all assessments to his component society for transmittal to this Association. All monies collected by each component society for transmittal to the Hawaii Medical Association shall be transmitted at least monthly (b) The annual dues of the American Medical Association shall be collected and transmitted in a like manner. (c) The annual dues of new members shall be prorated on a quarterly basis. (d) Honorary members shall be exempt from all dues and assessments of the Association.

Section 2. Waiver of Dues. (a) The Council may excuse members from payment of dues, provided they are fully or partially excused from payment of component society dues, and provided the request for exemption is transmitted through the component society to the Secretary of the Hawaii Medical Association, except that the dues of any member who celebrated his 70th birthday prior to January 1 shall be automatically waived without action by his component society. Dues may be waived for a period beginning January 1 or July 1 following the date of the member's change of status for: (1) a member who is temporarily in the Armed Forces not to exceed two years, (2) a member who enters postgraduate training for a period of at least one year, (3) a member who has retired from active practice, (4) a member for whom the payment of dues would prove a financial hardship, and (5) interns and residents. (b) Request for waiver of dues must be reconfirmed in writing by the Secretary of the member's component society within 90 days after the beginning of each fiscal year for which the extension of the waiver of dues is requested, except that waiver of dues for a portion of a calendar year need not be reconfirmed until a full year has passed since the date the waiver became effective. (c) A member whose dues have been wholly waived will not receive the HAWAII MEDICAL JOURNAL except by subscription.

Section 3. Delinquency. (a) A member is delinquent if his dues are not received by the Association prior to the expiration of the first ninety days of the year for which dues are prescribed and shall forfeit his membership in the Association if he fails to pay the delinquent dues within 30 days after the notice of the delinquency has been mailed to his last known address by the Secretary of the Association. (b) Members whose dues or assessments are not paid shall not be considered to be members in good standing of this Association. (c) Members of the Association who have been dropped from the membership roll for nonpayment of annual dues or assessment cannot be reinstated until their indebtedness has been discharged, but such indebtedness shall apply only to the one year of delinquency.

Section 4. Assessments. (a) An equal per capita assessment may be levied upon the active members of this Association by a two-thirds vote of the members of the House of Delegates present and voting at any of its sessions; provided, however, that such an assessment shall not exceed $25 per member per year without referendum. Life members shall be exempt from assessments of this Association.

Section 5. Special Funds. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the House of Delegates.

Section 6. Expenses. The general fund shall consist of all the monies received other than those specifically allocated to other funds by these Bylaws. This fund shall be used for defraying all expenses incurred by the Association not otherwise provided for in these Bylaws.

CHAPTER X — Fiscal Year

Section 1. (a) The fiscal year of the Association shall be the calendar year. (b) The dues year shall be the fiscal year.

CHAPTER XI — Miscellaneous

Section 1. (a) No address or paper before the Association except those of the President and invited speakers shall occupy more than twenty minutes in delivery; and no member shall speak longer than five minutes in discussing an address or paper before the Association, nor more than twice on any subject, except by unanimous consent.

Section 2. All papers read before the Association or any of its sections shall become its property and may not be published in whole or in part except by prior arrangement with the Scientific Program Committee. Each paper shall be deposited with the Secretary when read.

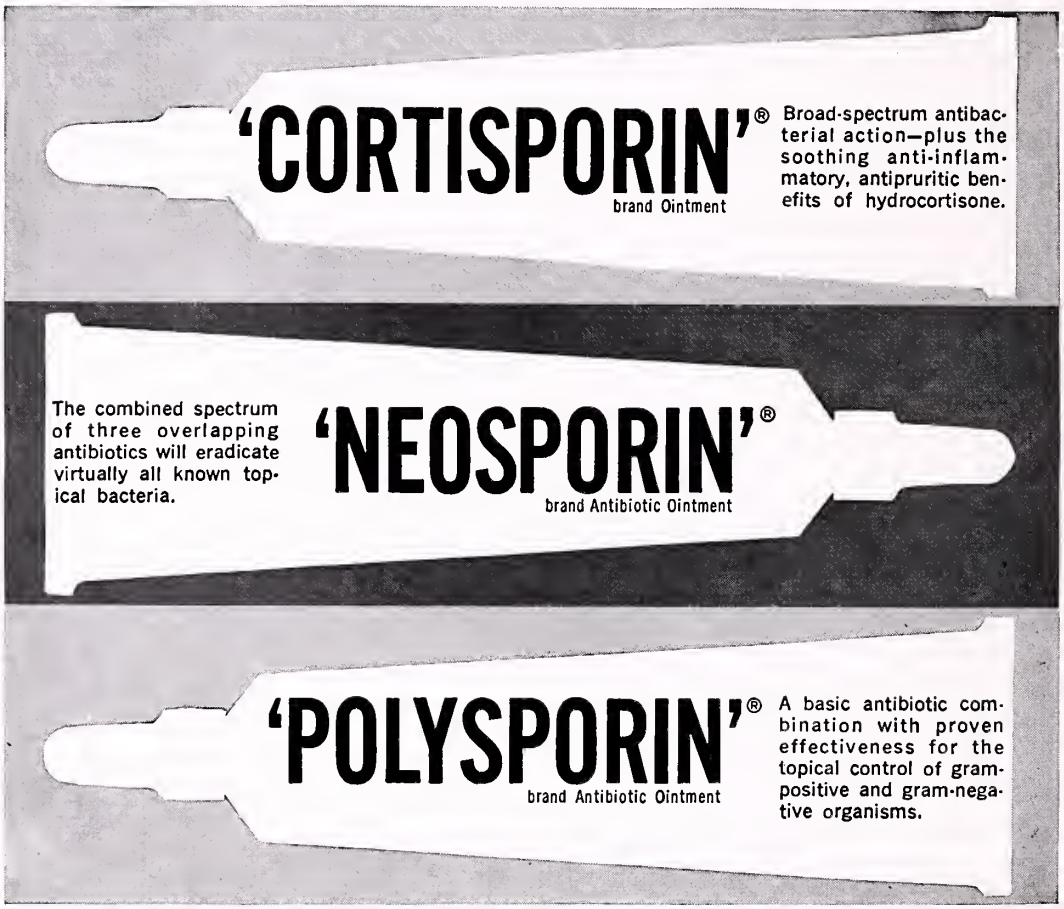
Section 3. The deliberations of the Association shall be governed by parliamentary usage as contained in Robert's Revised Rules of Order, when not in conflict with the Charter and Bylaws.

Section 4. The Principles of Ethics of the American Medical Association shall be the Principles of Ethics of the Hawaii Medical Association and of its component societies and shall govern the conduct of the members in their relations to each other and to the public.

CHAPTER XII — Amendments

Section 1. (a) These Bylaws may be amended at any meeting of the members of the Association when notice of such purpose of the meeting is given to all members by a majority vote of the members present and voting provided that notice of the substance of any proposed amendment shall be mailed to either each member of the Association or to the President of each component society at least sixty days prior to the date of the meeting at which the vote is taken, provided further that after such notice changes in such proposed amendments may be adopted at a meeting without further notice to the members.

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Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

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INTER-ISLAND NURSES' BULLETIN

Official Publication of the Hawaii Nurses Association

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*The American Nurses' Association**

The American Nurses' Association is to the nurse what the American Medical Association is to the physician and the American Bar Association is to the lawyer. The public recognizes the ANA as the professional organization which speaks for the nurse and protects her interests.

Support and participation in the organization is a professional duty. Through payment of dues the organization is supported, but direct benefit to the nurse comes from active participation as a member of a committee, or as chairman of a committee, or as chairman of a section. In this way the nurse learns the structure and goals of the association and she soon becomes familiar with the district, state, and national associations. This gives her the privilege of using her voice and vote to secure working conditions which improves her efficiency, educational opportunities, and better salaries which elevates her professional status and induces other well qualified women and men to enter nursing.

Through the ANA Legislative Program, nurses now have Social Security benefits, income tax deductions for care of dependents, and higher ranks for Army and Navy nurses. Through the Economic Security Program, nurses now have professional liability insurance and a shorter work week. The ANA is now working for salary increases comparable to that of other professional workers. The ANA has set up standards, functions, and qualifications for registered nurses in order to define their status among the many auxiliary workers.

Through the support of the ANA, nurses can obtain government traineeships to further their education in the form of substantial fellowships. Wise counsel on professional problems is available through the Professional Counseling and Placement Service.

Interest in the ANA should begin with the admission of the student to the school of nursing. The student should be impressed with the fact that she is entering a school to prepare herself as a professional person. She should be made aware that certain things are expected of a mature professional person, that are not expected of a person who merely holds a job.

It was hoped that the National Students Nurses' Association would carry over to the ANA after registration. A recent survey showed that nurses who are non-members of their association are those in the youngest age group.

Should employers require nurses to be members of the ANA? This is an argument that goes on far into the night. Some maintain that it is not democratic; others consider this coercion. Some maintain that the school is responsible for the development of appreciation of the benefits of her organization.

There are now approximately 460,000 employed registered nurses in the United States. Of these, 191,000 are members of the ANA. This means that less than half of the employed nurses support and give time and energy which results in benefits enjoyed by the other 259,000.

This large group of nurses are merely "utilizers." They are not truly professional nurses, but are only interested in getting the job done with the least effort to themselves.

This editor agrees with former President Theodore Roosevelt: "I hold that every man owes something of his time and substance to the upbuilding of the profession or industry from which he gains his livelihood."

LENA DIXON DIETZ, R.N.

* *The Davis Nursing Survey*, February, 1961.

Collective Bargaining

A bill, specifically establishing the right of professional nurses to collective bargaining, was passed recently by the Oregon state legislature, the first such law to be enacted anywhere in the country.

The bill, expected to be signed by the governor within a short time, calls for collective bargaining between employers and nurses in nonprofit and proprietary hospitals and nursing homes. It was introduced by the Oregon Nurses Association, a constituent of the American Nurses' Association, national professional organization of registered nurses.

A bill, introduced by the Pennsylvania Nurses Association, is now pending in the Pennsylvania House of Representatives. It would establish the right to collective bargaining for both professional nurses and nonprofessional personnel. It has been strongly opposed by the Pennsylvania Hospital Association.

Bills, providing for collective bargaining by hospital employees, have been introduced in seven states by other groups in 1960 and 1961: California, Connecticut, Illinois, Massachusetts, Montana, New York and West Virginia. The state nurses associations in California, Connecticut, Illinois, Massachusetts and New York have presented testimony in support of the proposed bills.

The American Nurses' Association, since 1946, has carried on a Economic Security Program to secure improved salaries and working conditions and to establish the right of professional nurses to a voice in their employment conditions. The program is conducted through the state constituent associations. A major obstacle has been the fact that nonprofit hospitals are excluded from provisions of the federal Taft-Hartley Act and nearly all state labor legislation and, therefore, have had no legal obligation to enter into collective bargaining with nurses or other employees. In most instances they have refused to do so on a voluntary basis.

Nurses have officially adopted a no-strike policy through action of the ANA House of Delegates, so they have had little recourse when employers have refused to meet with them to discuss employment conditions.

The Oregon law, which covers practical as well as professional nurses, sets as public policy the encouragement of collective bargaining between employers and employees in both publicly and privately operated health care facilities and brands failure to do so an unfair employment practice. It contains provision for mediation through the state conciliation service. It is expected that the Oregon law will establish a precedent for action in other states, thus opening the way for substantial improvements in the economic status of professional nurses. Currently, according to the ANA, the average salary of general duty nurses in the country is about $3,800. A recent survey by the Bureau of Labor Statistics of 15 metropolitan areas showed general duty weekly salaries in nongovernmental hospitals ranging from $67 in Atlanta to $85 in Chicago and Los Angeles–Long Beach.

Mr. Hudson to ANA Staff

James L. Hudson, R.N., formerly associate executive secretary of the New Jersey State Nurses' Association, has joined the headquarters staff of the American Nurses' Association. Mr. Hudson will have charge of the Nursing Service Administrators Section of the ANA, national professional organization of registered nurses.

A native of Bethany, Ill., Mr. Hudson received his nurses training at McLean Hospital, Waverly, Mass., his B.S. degree from the University of Pennsylvania and an M.A. from New York University. His former positions include those of assistant director of nurses, Jersey City Medical Center; administrative assistant, United States Naval Hospital, Norfolk, Va.; supervisor of clinical teaching, McLean Hospital, Waverley, Mass.; special lecturer, Germantown Hospital, Germantown, Pa.

Mr. Hudson has been secretary-treasurer of the New Jersey Board of Nursing and chairman of the Nursing Committee, Council of Social Agencies, Newark, N. J. He is also the author of articles on nursing, published in the *New Jersey Nurse.*

*Selected Highlights from Summary of SNA Economic Security Program Policies and Activities, 1960**

As of March, 1961, forty-eight constituent associations have adopted an economic security program.

During 1960, twenty-one SNA's reported specific instances of action taken to represent nurses in their individual employing agency. About 18,000 nurses were involved in these activities and an additional 3,300 nurses were covered by agreements which had been negotiated by SNA's but did not come up for negotiation during this period.

Agreements in effect as of December 31, 1960, covered 112 employers and about 8,000 nurses.

Twenty-seven SNA's reported a total of 480 local units in existence as of December 31, 1960. Although 70 percent of these local units were for general duty nurses, local units were also formed by such groups as private duty, public health, head nurses, supervisors, nurse educators and occupational health nurses.

During 1960, 37 SNA's had revised or set up new minimum employment standards for all or part of the various occupational groups within the state. Twenty-two SNA's reported that the basic 8-hour fee for private duty nurses was the same in all districts of the state.

Special meetings on the economic security program were held in 12 states during 1960 and an additional 6 SNA's reported on special convention

* The information included here was compiled from reports received by ANA from the state nurses associations during 1960. In some instances information received during the spring of 1961 is included.

program meetings on economic security. District nurses associations' programs on economic security were reported by 14 SNA's.

Nineteen SNA's reported some kind of activity in the area of legislation affecting the economic interests of nurses. The types of legislation considered included state labor relations acts, workmen's compensation, unemployment insurance and legislation related to specific groups of nurses such as state employees, school nurses and private duty nurses.

In 1961, the legislatures in two states, Oregon and Pennsylvania are considering bills covering collective bargaining in hospitals and other health services which were sponsored by the state nurses associations. The Oregon bill has been passed by the 1961 session of the lower house and still has to go through the upper house. The Pennsylvania House of Representatives is considering that bill at the present time.

Salary Survey

General duty nurses employed in nongovernmental hospitals in fifteen major metropolitan areas throughout the country from New York to Los Angeles are being paid substantially less than other employees in their communities whose jobs require equal or less training than nursing. This is revealed in the 1960 survey of these areas just released by the Bureau of Labor Statistics of the U. S. Department of Labor.

The survey shows that average salaries for general duty nurses range from $67 per week in Atlanta to $85 per week in Los Angeles–Long Beach and Chicago. The lower half of this average salary range ($67-$78) is prevalent in Atlanta, Baltimore, Cincinnati, Buffalo, Dallas, Memphis and Philadelphia while the upper half of the range ($78-$85) is in force in Los Angeles–Long Beach, San Francisco–Oakland, New York, Boston, Chicago, Cleveland, Minneapolis–St. Paul, and Portland, Oregon. By contrast, average salaries for secretaries in these areas range from $71 to $95 per week. Wage levels are consistently higher in state and local government hospitals than in voluntary hospitals. Federal hospitals were omitted from this latest study.

General duty nurses are also paid less than factory workers and classroom teachers. The American Nurses' Association has estimated that the average annual salary of the approximately 90,000 general duty nurses employed in nongovernmental hospitals throughout the country is about $3,800. The average annual salary for factory workers is about $4,700 and for classroom teachers about $5,200.

One of the obstacles to improvement of nurses' salaries, according to Mrs. Judith G. Whitaker, executive secretary of the ANA, is the fact that nonprofit hospitals in this country are exempt from federal and most state labor legislation that would require them to enter into collective bargaining with their employees. The American Nurses' Association has long sought to have hospitals included under the Taft-Hartley Act so that hospitals would be required to negotiate with their employees as to employment conditions. A major breakthrough on the state level was achieved this month when the Oregon state legislature passed a law requiring nonprofit and proprietary hospitals and nursing homes in the state to negotiate with authorized representatives of professional and practical nurses. This law was sponsored and supported by the Oregon State Nurses' Association, a constituent of the American Nurses' Association.

Consultants on Nursing

President John F. Kennedy, in consultation with Secretary of Health, Education and Welfare, Abraham Ribicoff, has authorized the Surgeon General of the Public Health Service to establish a consultant group on nursing. Chairman of the group will be Dr. Alvin C. Eurich, Vice-President of the Fund for the Advancement of Education of the Ford Foundation.

The nursing profession is already facing an acute shortage, and the demand for augmented and new services essential for an adequate health program promises to grow. The advice of physicians, hospital administrators, nurses, educators, social scientists, and public health executives is being sought to help devise a program that will meet the needs of the Nation. The consultants who are expected to report to the Surgeon General, Dr. Luther L. Terry, by January 1, 1962, are:

Alvin C. Eurich, Ph.D., Vice-President, The Fund for Advancement of Education, Ford Foundation, New York, New York

James Z. Appel, M.D., private practice—surgery, member, AMA Board, Lancaster, Pennsylvania

Virginia L. Bonney, Instructor in Education and Director of Programs in Rehabilitation Nursing, New York University, New York, New York

Dorothy Breene, Director of Nursing, New Hampshire State Hospital, Concord, New Hampshire

Sister Virginia Kingsbury, Consultant to Schools, Western Provinces of Sisters of Charity, Marillac Seminary, Normandy, Missouri

Mary Kneedler, Chief, Public Health Nursing Sec., North Carolina State Board of Health, Raleigh, North Carolina

Eleanor Lambertson, Director, Division of Nursing, American Hospital Association, Chicago, Illinois

Mildred Lipsteur, Licensed Practical Nurse, Cleveland Clinical Foundation, Cleveland, Ohio

Evelyn Hamil, Director of Nursing Service & Education, Los Angeles County General Hospital, Los Angeles, California

Lulu Wolf Hassenplug, Dean, School of Nursing, University of California, Los Angeles, California
James Theodore Howell, M.D., Assistant Director, Henry Ford Hospital, Detroit, Michigan
Robert Merton, Ph.D., Associate Director of Applied Social Research, Columbia University, New York, New York
Marion Sheahan, Deputy Director, National League for Nursing, New York, New York
Mrs. Mabel K. Staupers, 2705—13th Street, N.E., Washington, D. C .
John Tomayko, Director, Insurance, Pensions, Unemployment Benefits, United Steelworkers of America, Pittsburgh, Pennsylvania
Herbert Longnecker, Ph.D., President, Tulane University, New Orleans, Louisiana
Marie Lowe, Director, Combined Nursing Service, Instructive Visiting Nurse Ass'n, City of Richmond, Dept. of Health, Richmond, Virginia
Florence Mahoney, 3600 Prospect Avenue, N.W., Washington, D. C.
William K. Turner, Director of Newport Hospital, Newport, Rohde Island
Mrs. Judith G. Whitaker, Executive Secretary, American Nurses' Association, New York, New York
William Willard, M.D., Vice-President, University of Kentucky, Medical Center, Lexington, Kentucky
Whitney M. Young, Executive Director, National Urban League, New York, New York

Nurse Wins Journalism Award

The Mary Roberts Fellowship winner for 1961 is Stella L. Brueggen, R.N., of Chicago, staff member of the Illinois Society for the Prevention of Blindness. The Fellowship, established in 1950 by the American Journal of Nursing Company in honor of the late nursing leader, is granted yearly to assist qualified nurse writers in developing their skills to better interpret nursing to nurses, prospective nurses and the general public.

Miss Brueggen receives full tuition fees for a year's study at a recognized school of journalism, $3,000 to cover living expenses for her study year and a three to six month internship on the Journal Company's editorial staff. Her winning article describes the role of the professional nurse in an eye bank program.

Presently on assignment as consultant to the Illinois Eye Bank, Miss Brueggen plans to enroll this fall in the Medill School of Journalism, Northwestern University.

The award winner, a native of Milwaukee, is a graduate of the Grandview School of Nursing in LaCross, Wisconsin, and has a bachelor of science degree in public health nursing from Loyola University in Chicago.

Mrs. Purcelle Peck Smith, former editor of *Public Health Nursing* headed the judging panel aided by Mrs. Helen W. Munson, recently retired librarian at the Hartford Hospital School of Nursing, and Kathleen Leahy, professor at the University of Washington. The three nurse panelists were assisted by author Mari Sandoz and novelist Wellbourn Kelley.

Honorable mention for the 1961 award went to Mrs. M. Marion Wood, assistant chief of Nursing education at the VA Hospital in East Orange, New Jersey, and Sister Mary Immaculata, F.M.S.I., now on leave of absence from her duties as supervisor in a medical mission clinic on Okinawa.

NEF Awards

When nurses in administrative and supervisory positions are well-prepared, all nursing care given under their direction is better. That's why, when graduate nurses want to prepare for posts of greater responsibility in nursing, they should be helped to do so. And that's why an organization like Nurses' Educational Funds exists.

NEF's awards are made to graduate nurses for advanced study in nursing. NEF's awards help nurses—and help insure good nursing care for those who need it.

We hope you will remind the members of your organization that they can still make a gift to NEF this year and start another nurse on a program of study to increase her usefulness. And remind them too that all gifts to NEF are deductible for income tax purposes.

The University and Nursing Education

It has been said that nothing is as certain as death and taxes. Now we can add "change" as well. Certainly there is no field in which change has not been experienced profoundly in this century, including nursing and nursing education. Indications are that we can say "we ain't seen nuthin' yet." A recent article shows how vital signs can be registered on a central indicator in the nursing station. Nurses may not be taking temperature and blood pressure or counting pulse and respiration in the future. Already many other procedures which we learned to do so skillfully through practice day after day are becoming obsolete because of new drugs, disposable supplies, or newly-discovered preventive measures. What are the things which nurses should be prepared for in the future—say in 10-15 years—when our present students are at the peak of their production and their leadership? Our crystal balls fail us. The only thing we can be sure of is that we shall be taking care of people and people have health problems with which they need help.

Universities have been given the particular responsibility of preparing for the future. Therefore, their philosophy, their goals, and their methods are different from those institutions preparing for a specific job at a specific time. Universities are

responsible for widening horizons. Their teaching must help students to explore and find new facts, new concepts, new ways of doing things. This is in contrast to a technical training which emphases the best way to do things now. From the University must come the people who can teach, guide and inspire the oncoming young people who are going to have to meet the profound changes which surely will come after their teachers are gone. This is a huge task. It goes far beyond meeting the nursing needs of patients today, as important as this is in the preparation of our students.

The University of Hawaii, along with other colleges and universities which prepare nurses, is faced with meeting this challenge. Not knowing what demands she must face tomorrow, the student must have as a tool those basic facts which are as scientifically sound as our present knowledge can make them. These she will use to enable her to judge and effect change in nursing practice safely and effectively when altered attitudes, unheard of discoveries, and new knowledges make change possible or necessary.

Already much of nursing has become a supportive and teaching function rather than an administering one. Today we no longer think it necessary to give months even weeks of bed care. It is being said that no patient except the unconscious one need be a long time in bed. Our goal then is to assist patients to use their own minds, wills, and bodies to become as normally active as they can as soon as they can. We should expect this movement to increase in the future. The nurse then needs not practice in giving baths, making beds, and in technical procedures so much as she needs skill in helping the patient to identify his own problems and skill in assisting him to meet his problems in order to recover his health, accept his disabilities, and learn new ways of living.

If present trends continue, the nurse will increasingly find herself a contributing member of a team which plans individual patient care. She must be able to discover, organize, measure, and present facts which only she as a nurse in more frequent contact with patients can obtain. In other words, be able to make her unique and essential contribution to the team because she is closest to the patient. For this she needs certain investigative skills.

In some circles the theory is gaining ground that all illness is psycho-initiated. If this comes to be our focus in the future, the knowledge of workings of the mind will be just as important as the workings of the body, if one can ever separate the two. Interviewing and counselling skills will be as important as skill with the hands.

We spoke previously of the "unique" contribution of the nurse. What is the "unique" function of the nurse now and what is it to be in the future? Many leaders in nursing are considering that our most urgent problem is to identify "what nursing is." As a step toward this, Abdellah in her book called *Patient-centered Care* has listed 21 problems of patients which require nursing intervention. Nursing care is based on problems which the patient experiences. The nurse's functions are recognition of the patient's problems or stresses which his condition causes to arise, knowledge of the changes taking place because of the condition, decision as to the intervention which the nurse needs to undertake, and understanding of the results that her intervention brings about. Therefore, the student's time must be spent not on repetitive practice of isolated procedures or tasks but on total care of a limited number of patients. She must have time and opportunity to identify the problems of the patients under her care and gather the knowledge she needs to understand them. Then she will decide on a plan of care to help the patient and his family meet problems, and will evaluate what effect on his health intervention has. This we call problem solving.

This means for the student carefully selected patients which present a variety of nursing problems, time to study charts, read books, have conferences with physicians, social workers, special therapists and the like, talk with patient, and faculty members and find community resources for referral as necessary.

This kind of study calls for opportunity for concurrent classroom and clinical instruction in order to identify principles involved in patient care and to apply them in practice. It demands careful selection of learning experiences without necessity for providing service to the agency and with freedom to pursue those meaningful experiences which lead into the home, school, and community. Teachers must be especially knowledgeable and competent in their field of teaching. They must be able to select essential learning experiences, determine desirable behaviors which indicate progress toward pre-determined goals, and evaluate achievement on the basis of those behaviors. They must be imaginative and creative in finding ways to motivate students to learn and in finding ways to meet their needs.

Through the intensive curriculum study which has been going on in the College of Nursing at the University of Hawaii, the faculty has been trying to establish philosophy and goals, select and organize learning experiences, determine content and desired behaviors, and find effective ways of guiding students' learning toward ever-increasing depth of understanding and application of knowledge. This, we hope, will result in nurses who are sensitive to all persons' needs, including their own; nurses who are able to help others to identify their

problems and find effective ways of meeting them, and nurses who are capable of giving patient-centered care within the family context. They should be prepared to be uniquely contributing members of the health team and leaders in the democratic way of guiding others to meet their greatest potentialities. All of this and a well-rounded person in her own right! Such a nurse will soon learn to apply these skills in the individual environment of each job she holds in a way to make her contribution to patient-centered care increasingly valuable.

It is the task of the University to provide these learning opportunities not only for the young woman entering nursing but also for the graduate nurse who wishes to become more expert in nursing care either as a practitioner or as a supervisor, administrator or teacher. As the University College of Nursing expands its facilities and faculty, it hopes to offer the graduate nurse such opportunities through non-credit continuation education programs, and through advanced work on a Master's level as well as in its presently developing baccalaureate program.

With our minds on knowledge, our hearts on patient's needs, and our energies turned toward ever-improved ways of meeting those needs we should be able to face any challenges that the future brings.

VIRGINIA A. JONES
Dean

Red Cross Visitor Honored

Among distinguished visitors to Honolulu during May was Miss Yvonne Hentsch, Director of the Nursing Bureau of the League of Red Cross Societies. Nursing leaders and Hawaii Red Cross Board members honored her at a tea on May 3.

Miss Hentsch is a graduate of La Source School of Nursing, Lausanne, Switzerland, the world's oldest endowed School of Nursing (1859) and a Red Cross institution since 1923. She has done postgraduate work as a Florence Nightingale International Foundation student at Bedford College, the Royal College of Nursing in London, and at Teachers College, Columbia University, New York. In addition, she holds a Certificate in Public Health Nursing from the School of Social Work, Geneva. As Director of the League's Nursing Bureau, Miss Hentsch advises and assists National Societies in developing National Nursing Services, including training and enrollment of professional nurses; training and enrollment of nurses' aides; development of home nursing instruction programmes; and award of scholarship, fellowship, and study grants to their own nationals, or those of countries recommended by sister national societies, for study outside their own country in the field of nursing.

She also assists in the planning of nurses, participation in League relief operations, such as in Agadir following the disastrous 1960 earthquake, in Meknes after the oil poisoning of some 10,000 people, in the Congo, etc.

In addition to missions, Miss Hentsch maintains contact by correspondence with most of the 85 national societies, Members of the League. Miss Hentsch is a Member of the World Health Organization's Expert Advisory Panel on Nursing (since 1951) and of the Ethics of Nursing Committee of the International Council of Nurses. She was Chairman of the Florence Nightingale International Foundation Council, 1955-1957. Appropriately, for an international staff officer, she was born of a Swiss father and an English mother, and speaks five languages—English, French, German, Italian, and Spanish.

Miss Hentsch's ten-week, round-the-world trip, March-May 1961, was planned in connection with her representation of the League at the 12th Quadrennial Congress of the International Council of Nurses held in Melbourne, Australia, April 17-22. A meeting of Red Cross Nurses attending the Congress was arranged under the auspices of the Australian Red Cross. Miss Hentsch also visited the National Red Cross Societies of Burma, Ceylon, Indonesia, New Zealand, and the U.S.A. While in Australia, she visited the Society's Northern Territory, Queensland, New South Wales, and Victorian Divisions.

In Burma, her visit coincided with a special effort made by the Burma Red Cross to explore the possibility of extending its Nursing Activities, both Auxiliary and Professional.

In Indonesia, the National Red Cross Society is planning to expand its activities in home nursing, first aid, and the training of nursing staff. The League's Nursing Director was invited to consult with home nursing instructors and supervisors at Djakarta, Bandeng and Jogja. She discussed "The Role of Nurses in Blood Transfusion" at the Society's First National Red Cross Seminar on Blood Transfusion, held in Djakarta April 1-6. In Bogor, she addressed students of the Red Cross School of Nursing and attended first aid and disaster relief training demonstrations.

In Ceylon and New Zealand, Miss Hentsch met Red Cross Voluntary Aid Detachment Members and discussed their programs of activities.

In the U.S.A. she was the principal speaker at the Nursing Services luncheon meeting held in connection with the 1961 American Red Cross Convention in Cincinnati, Ohio, on May 9th. She also visited the Society's Headquarters in Washington, D. C., and several Chapters.



WELCOMED TO MAUI DISTRICT NURSES ASSOCIATION in April by Mrs. Grace Lusby, HNA Board representative from Maui, and Mrs. Marjorie Okinaka, President of Maui District Nurses Association, were Mrs. Ann Zimmerman, Executive Secretary of Illinois Nurses Association, ANA Board member and official delegate to ICN, 1961, and Miss Barbara Schutt, Editor of American Journal of Nursing.

Book Reviews

Patient-centered Approaches to Nursing

By Abdellah, Faye G.; Beland, Irene L.; Martin, Almeda; Matheney, Ruth V., Macmillan Co., 1960.

Are you looking for suggestions, provocative, practical, scientifically sound as revealed by research findings, whereby it would appear feasible and realistic to develop a curriculum in nursing or a nursing service based on "Common Human Needs" as they are modified by illness or health situations?

Do you truly want assistance in finding ways, whether your nursing focus is service or education, to provide, or give, or help a student to learn to give, effective individualized nursing care that has its approaches "patient-centered" with implications for extending these approaches, as appropriate to family and community-centered care?

If so, there is a real possibility you will find within the two hundred odd pages of this little book, much that is thought provoking, factual, timely, and disturbing. Even more important, here are to be found ideas that are usable.

The authors raise a number of very pertinent questions relevant to our present cherished ideas and practices which we will need to be willing to face and analyze, provided that there is willingness and desire on our part to find ways that will permit the student in nursing to comprehend and to learn how to practice, and the graduate nurse to practice day by day, the kind of nursing that *is* patient-centered.

This little volume could well constitute an important source book from which definitive action could be formulated, assuming we want to attempt to put into action ideas that hold rich promise for improved nursing care to patients, their families and their communities.

MARGARET S. TAYLOR

Aspects of Public Health Nursing

By Esther L. Brown, Ph.D., et al, 185 pp., $1.75, World Health Organization, 1961.

An international symposium of 13 papers dealing with many aspects of public health nursing, including discussions of its application in Russia, Brazil, and France. Paper-bound. It would be most valuable to workers in this field.

HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

CAROLYN E. MCCUE, *Editor* BERYL UYEHARA, *Associate Editor*

President's Message

The past year has been a most successful and productive one thanks to much time and effort put in by members of the Society. The Hawaii Extension of the 29th Annual ASMT Convention, our most ambitious undertaking to date, was certainly the high point and a wonderful closing for the 12th year of the HSMT.

This year let's continue the good work. The success of our society or any similar organization depends upon its members. The HSMT needs more help and cooperation from its members if it is to grow in professional status. This year let us put a greater emphasis on getting more medical technologists to join the society and to take an active part in its functions. Let's make this year mark the greatest growth of the society so there can be no doubt that the Hawaii Society of Medical Technologists is truly an organization that represents the medical technologists of Hawaii.

MASAJI NAKAGAWA

Annual Meeting

The annual meeting of The Hawaii Society of

The annual meeting of the Hawaii Society of Medical Technologists was held at uKakini Hospital on May 9. Several revisions were made in the constitution and officers for the 1961-1962 year were elected. The following technologists will head the organization for the term starting July:

PRESIDENT-ELECT: Mrs. Betty Hughes, Hawaii State Hospital
RECORDING SECRETARY: Edith Eckstein, Tripler Army Hospital Blood Bank
CORRESPONDING SECRETARY: Mrs. Flossie Kamikawa, St. Francis Hospital
TTREASURER: Kenneth Sato, Kaiser Foundation Hospital

The constitution revisions provide for the inclusion of five new standing committees: finance, recruitment, education, publications and public relations, and convention. An amendment was passed which provides for absentee ballots.

Characterization of Non-Typable Staphylococcus aureus with Locally Isolated Staphylococcus Bacteriophages

During the past year, attempts were made to isolate new bacteriophages possessing lytic properties against some of the staphylococcus strains which were found untypable with the set of 21 basic phages (designated by the International Subcommittee on Staphylococcus Phage Typing*) and seven others, the originals of which were received from Dr. John E. Blair, Hospital for Joint Diseases, New York City, N. Y.** The technique used in the bacteriophage typing was that described by Blair and Carr.

Although 19.9 per cent of 2,011 Staphylococcus aureus cultures submitted to this laboratory for phage typing in 1958 were not typable with 24 basic phages, 32.3 per cetn of 1,959 strains in 1959 and 32.1 per cent of 2,549 strains in 1960 were found to be nontypable. It was felt that new phages isolated locally, especially from the pharyngeal areas which seem to provide the largest number of nontypable strains, might be employed advantageously in identifying additional strains of staphylococci which otherwise would be reported as nontypable.

Method

Five new phages were isolated by Fisk's cross culture method (2) and these were designated as RT-1, RT-2, RT-3, RT-4, and RT-5. The technique employed was to streak the surface of Trypticase Soy Agar plates with four-hour broth cultures of Staphylococcus aureus which had been found to be unaffected by any of the 28 standard typing phages. Each of these streaks was spotted with a drop of supernatant from 6–8-hour broth cultures of Staphylococcus aureus submitted to this laboratory for phage typing. When plaques were observed after overnight incubation, the phages were repeatedly propagated on respective host cells until sufficiently high titers were obtained. Critical Test Dilution (CTD) titers of 1×10^4 to 1×10^6 were thus readily acquired.

Phages designated RT-2, RT-4, and RT-5 were isolated from throat cultures and RT-3 from an ear lesion. Although RT-1 was propagated earlier from a foot lesion culture, it was found to be identical or very similar to RT-5 in its cross reaction patterns with the respective propagating strains as well as with the 28 propagating strains of the standard typing phages. In routine application RT-1 was found to be somewhat weaker than RT-5, the general pattern with the CTD being RT-5 (complete lysis)/RT-1 ($\pm$ to $+$) and with the more concentrated 100×CTD, RT-5 (complete lysis/RT-1 ($++$ to complete lysis). No cross lysing was observed

* 29, 52, 52A, 79, 80, 3A, 3B, 3C, 55, 71, 6, 7, 42E, 47, 53, 54, 73, 75, 77, 42D and 187.
** 83, 44A, 81, 39, 42B, 70 and 523.

among RT-2, RT-3, RT-4, and RT-5. None of the 28 typing phages lysed any of the host cultures used in propagating these RT phages and conversely none of the RT phages lysed the 28 propagating staphylococcus cultures except phages RT-1 and RT-5 which lysed only PS 73 at CTD. To avoid confusion the designation of RT-5 was adopted to indicate cultures which reacted with phages RT-5 and RT-1.

Findings

Phage RT-2 failed to identify any of the 256 nontypable strains received during a four months test period and, therefore, was excluded from further use. During a six months period (October, 1960, through March, 1961) there were 434 Staphylococcus aureus cultures which were not typable with the routine set of 24 phages. Of these 64 or 14.7% were lysed by RT-3, 21 or 4.8% by RT-4 and 115 or 26.5% by RT-5, a total reduction of 46.1% in the number of nontypable cultures from 434 to 234.

As presented in Table 1 the RT-5 and to a certain extent RT-3 have occupied predominant positions in the frequency distribution of the various phage types encountered during this six months period.

TABLE 1. *Number and Relative Position in the Order of*

MONTH	PREDOMINANT PHAGE TYPE AND FREQUENCY OF OCCURRENCE*	NUMBER OF RT CULTURES AND THE ORDER OF PREDEMINANCE		
		RT-5	RT-4	RT-3
Oct. 1960	80/81 (64), 52/52A/80 80/81 (53), 7 (19), 3A (13)	(15) Third	(2)	(5)
Nov. 1960	80/81 (50), 7 (17), 83 (12)	(18) Second	(7)	(16) Fourth
Dec. 1960	80/81 (55), 7 (19), 3A (19), 83 (10)	(15) Fifth	(3)	(17) Fourth
Jan. 1961	80/81 (40), 3A (22), 7 (18)	(30) Second	(4)	(9) Fifth
Feb. 1961	80/81 (54), 7 (19), 3A (12)	(21) Second	(2)	(6)
Mar. 1961	80/81 (64), 52/52A/80 (18), 7 (13)	(16) Third	(3)	(11) Fifth

* Number enclosed in parenthesis indicates frequency of occurrence.

Predominance of RT-3, RT-4 and RT-5 Cultures. (October, 1960, through March, 1961)

Thus phage type RT-5 occupied second position in the order of frequency three times, third twice, and fifth once whereas RT-3 occupied fourth position twice and fifth position twice.

Table 2 shows that RT phage types were found among cultures submitted by clinics and physicians, as well as, hospitals and also among cultures submitted from the neighbor islands.

TABLE 2. *RT Phage Types by Agencies Submitting Cultures*

PHAGE TYPE	NUMBER OF CULTURES SUBMITTED BY		
	Clinics and Physicians	Hospitals	Other Islands
RT-5	11	100	4
RT-4	2	19	
RT-3	3	58	3

Although the information submitted with the cultures was by no means complete or sufficiently descriptive, particularly in respect to the source of lesion, an attempt was made to group the 115 RT-5, 21 RT-4, and 64 RT-3 cultures by source.

As shown in Table 3, half of the cultures found typable with phages RT-3 and RT-4 were obtained from nose, throat, sputum, or sinus specimens, whereas, only 16 per cent of cultures typable with RT-5 were in this category. Undoubtedly some of these cultures may have been submitted for carrier study purpose rather than diagnostic but the significant number of isolations of these phage types from lesions is indication of their infectivity.

TABLE 3. *Source and Number of the RT Identified* Staphylococcus aureus *Cultures*

SOURCE	RT-5	RT-4	RT-3
Nose, throat, sputum, sinus	18 (16%)	11 (52%)	32 (50%)
Head neck, face, eye, ear	11	2	5
Upper limb	9	2	3
Lower limb	24 (21%)	3	9
Shoulder, axilla, trunk, hip	5		2
Urogenital region	2		
Buttocks	2	1	
Crine	4		3
Blood	2		
Kidney	1		
Scrapings, skin lesion			5
Abscess, furuncle, boil, pustule, drainage, wound	37 (32%)	2	5
Total	115	21	64

Although repeat cultures were very rarely submitted, there were a few instances in which multiple isolations of identical phage type were noted in the same individual. There were four such individuals with RT-3, one with RT-4, and nine with RT-5, as listed in Table 4.

TABLE 4. *Repeat Isolations of Identical Phage Type from*

PATIENT	DATE	SOURCE	PATIENT	DATE	SOURCE
	(RT-3)			(RT-5)	
F. C.	11/2	scalp	N. K.	10/27	nasopharynx
	12/8	urine		10/28	throat
				10/30	nasopharynx
M. O.	10/28	throat			
	11/10	throat	C. S.	12/7	foot
				12/9	heel
J. S.	11/28	skin		12/9	left foot
	12/5	skin			
	also		A. T.	12/5	urine
	12/5	skin		12/19	urine
	1/4	skin		12/27	kidney absc.
A. S.	11/3	urine	A. .G	1/16	right ear
	12/9	urine		1/16	boil on arm
				1/23	right ear
R. C.	(RT-4)		W. R.	10/6	wound
	11/16	right knee		10/10	wound
	11/16	buttocks	L. Y.	1/16	left forearm
				1/18	right thigh
			V. C.	2/21	right leg
				2/23	throat
			S. K.	2/8	blood
				2/20	right ankle
			L. S.	2/9	right foot
				2/24	right foot

Antibiotic Sensitivities

Of the 115 type RT-5 cultures tested with commercial sensitivity discs (low concentrations*) 55 or 47.8 per cent were found to be resistant to penicillin. One was

* aureomycin 5 mcg., penicillin 2 units, chloromycetin 5 mcg., terramycin 5 mcg., erythromycin 2 mcg., tetracycline 5 mcg., dihydrostreptomycin 2 mcg., oleandomycin 2 mcg., bacitracin 2 units, neomycin 5 mcg., carbomycin 2 mcg. and novobiocin 5 mcg.

resistant also to aureomycin, chloromycetin, terramycin, tetracycline, and dihydrostrephtomycin and another to aureomycin, terramycin, tetracycline, and dihydrostreptomycin. None of the 64 RT-3 cultures or the 21 RT-4 cultures was found to be resistant to any of the antibiotics tested.

Discussion

The inclusion of RT-3, RT-4, and RT-5 phages into the routine typing set does not mean a whole scale reduction in the number of nontypable strains. However, during the past six months the utilization of these three phages has reduced the number of nontypable strains from 434 to 234 or by 46.1 per cent.

Blair and Carr[1] found 44.7 per cent of 539 cultures not typable in 1953. As a result of examining 748 cultures isolated from patient lesions, aBas and Felton[2] attributed nontypable strains to 26 per cent of patient lesions. More recently (1960) Blair and Carr[4] found that with CTD and 1,000×CTD phages the proportion of untypable cultures may be as high as 20 per cent. Anderson and Williams[5] stated that in recent years they have found only about 8 per cent untypable with the set of basic phages using CTD and 1,000×CTD.

Our experience has been 19.9 per cent untypable in 1958, 32.3 per cent in 1959 and 32.1 per cent in 1960 using the CTD and 100×CTD phages. The somewhat high percentages may be due to the wide range of origins and sources of the cultures submitted which were not limited to lesions alone. Untypable strains are encountered more commonly in cultures from the nose than from lesions[4,6]. During the nine months period prior to the adoption of RT-3, RT-4, and RT-5, 38.6 per cent of 488 nose and throat cultures from clinical sources were found to be untypable as compared with 26.6 per cent of 380 Staph. aureus cultures isolated from lesions. In a study of Staph. aureus cultures isolated from anterior nares of 132 prospective mothers at time of admission to maternity wards, nontypable strains were found in 43.2 per cent of these individuals (unpublished data). It is felt that continued isolation and propagation of new bacteriophages will further reduce the number of untypable *Staphylococcus aureus*. Then too, an accumulation of new phages to constitute a reserve battery or auxiliary typing set may prove to be of extreme usefulness in the event of localized outbreaks of staphylococcal infections in Hawaii.

Summary

Five new staphylococcal bacteriophages have been isolated and successfully propagated to working titer. However, only three of these have been found to merit practical application and have been designated RT-3, RT-4, and RT-5.

Other than by their corresponding phages, the propagating staphylococci RT-3, RT-4 and RT-5 were not lysed by 28 standard typing phages available in this laboratory. Of the 28 corresponding propagating staphylococcus cultures only PS 73 was lysed and then only by phage RT-5.

Of the 434 Staphylococcus aureus cultures which were not typable by the set of 24 basic typing phages, 64 (14.7%) were typed by RT-3, 21 (4.8%) by RT-4, and 115 (26.5%) by RT-5, resulting in an over-all reduction in the number of nontypable strains by 200 (46.1%).

That these phage types occupied significant positions in the order of predominance of the various phage types encountered during the six months of study has been presented. They were found among cultures isolated from lesions, as well as, from nose and throat specimens. They appear to be widely dispersed, in as much as, they were found among specimens submitted by clinics, physicians and hospitals on this island as well as those on the neighbor islands.

Resistance to antibiotics was observed only with the RT-4 strains. Of the 115 RT-5 cultures, 47.8 per cent were found to be resistant to 2 unit penicillin discs.

Continued search and development of newer bacteriophages will contribute significantly in furthering the characteriation of additional Staphylococcus aureus strains in Hawaii.

RALPH H. TANIMOTO, M.S.[1]

[1] Assistant Chief, Laboratories Branch, Department of Health, State of Hawaii.

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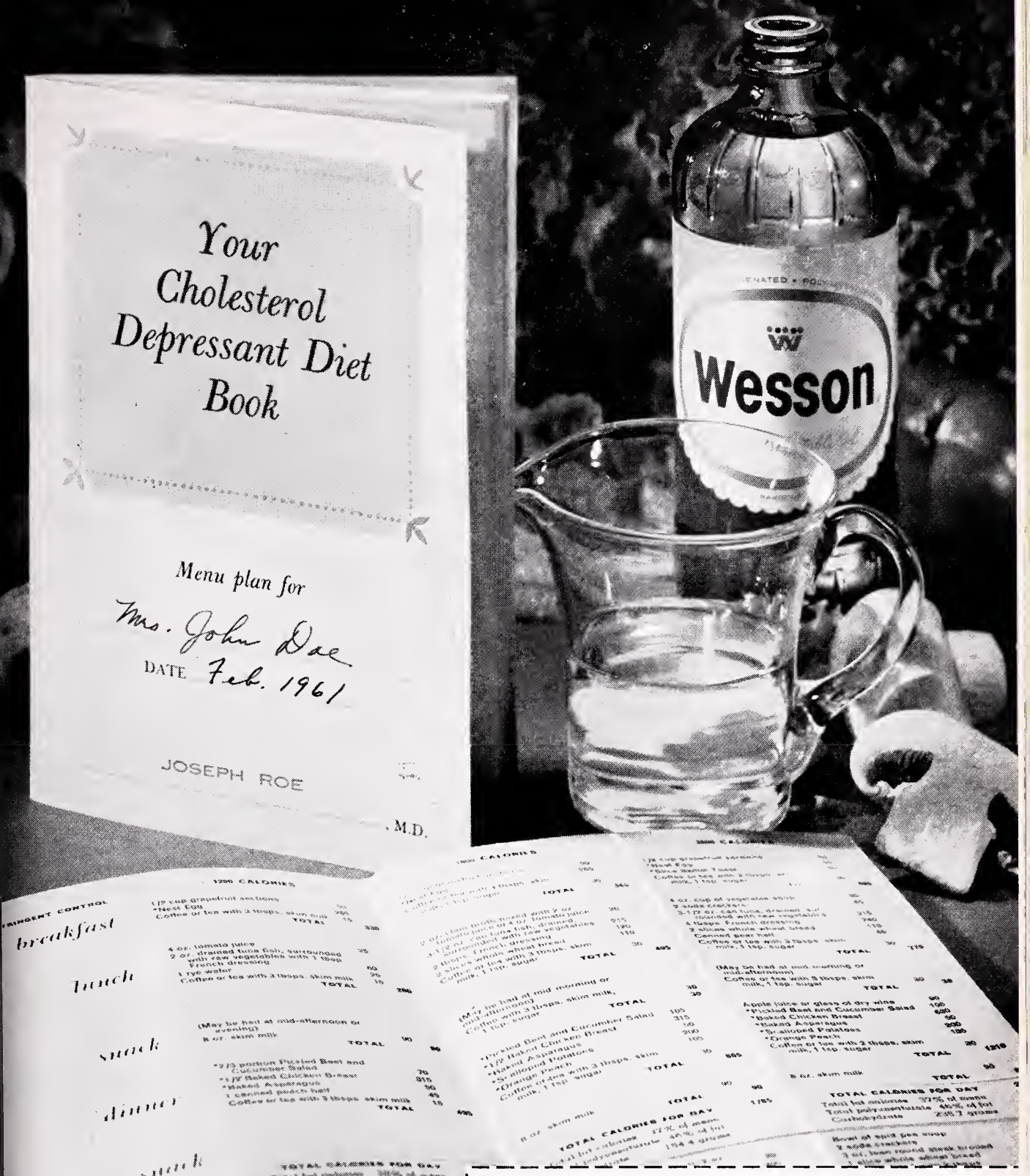
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IN MEMORIAM

(Continued from page 553)

versity and graduated in 1903. His medical degree was granted by Columbia University in 1907. Following his graduation, Dr. Hedemann went abroad for two years of study at the University of Vienna, specializing in children's diseases.

Dr. Hedemann returned to Hawaii in 1909 to begin his medical practice. He was associated with Drs. E. C. Waterhouse, J. R. Judd and W. D. Baldwin, which firm later evolved into The Medical Group.

Joining the U. S. Navy as a Lt. (jg) during World War I, he served as a physician at Mare Island, California, and later became a full lieutenant.

On June 3, 1914 Dr. Hedemann married Dorothy Hartwell in Honolulu. They had two children, Ferdinand Frederick, Jr. and Juliette Hedemann.

Dr. Hedemann served as visiting physician for Queen's and Children's hospitals. He was also a member of the Board of Pharmacy and of the Board of Health Civil Service Examiners.

Dr. Hedemann died July 26, 1927, in Honolulu at the age of 47.

He was a member of the Hawaiian Medical Society, Hawaiian Historical Society, University Club, Pacific Club, Oahu Country Club, Harvard Club, Hawaii Tuna Club, and the Hawaii Polo and Racing Club.

COUNTY SOCIETY REPORTS

(Continued from page 552)

A lengthy discussion followed with regard to the Federal Employees Medical Plan. The possibility of the Society's negotiating through the Stockton Plan was mentioned. The idea of individual contracts with HMSA was discussed, thereby doing away with individual contracts with the Society. It was brought out that there is nothing the Society has done to disapprove its participation in the Federal Employees Medical Plan. It was felt the Medical Society as an organized group should have a great deal to say about the negotiations for the new contract and the Society should take a stand on this matter. It was also felt that there should be a greater degree of understanding and satisfaction between the Medical Society and HMSA.

Dr. Carl Johnsen then moved the question which was seconded and carried, following which Dr. Katsuki's motion was voted on and was carried.

Dr. Moore suggested that perhaps the present contract between the Society and HMSA should be reviewed and revised to the effect that individual contracts with the Society be renewed annually and that the HMSA's Medical Committee be empowered to reject any individual contracts.

Dr. Frazer stated that HMSA would probably look favorably upon Dr. Moore's suggestion and it might go a long way in solving a lot of the problems in the Federal Plan and the contract with the Medical Society.

The Chair suggested that Dr. Moore's suggestion be referred to the Medical Care Plans Committee for study and recommendation.

Dr. Moore than moved his suggestion be made into a motion which was seconded by Dr. Frazer and was carried.

Dr. Chinn requested that the membership be informed of the action taken by the Society on Dr. Katsuki's motion and that they be circulated with this information. It was mentioned that HMSA will also be notified.

Meeting adjourned at 9:45 P.M.

R. D. MOORE, M.D.
Secretary

Maui

A regular meeting of the Maui County Medical Society was held on Friday, February 17, 1961, at the Wailuku Hotel. Guests present were Drs. Harvey, McGovney, Wallis, and Oliver Cope.

A dinner meeting was followed by a scientific meeting. The Medical Society was privileged to hear a delightful and an extremely interesting talk by Dr. Oliver Cope of Boston on parathyroid disease.

A letter about oral polio vaccine from the Polio Vaccine Committee of H.M.A. was read, and the staff, with Dr. Fleming moving and Dr. Shimokawa seconding, agreed to go along with this recommendation.

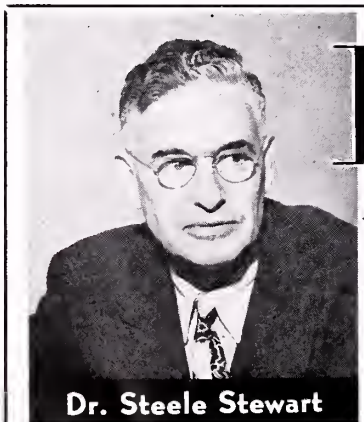
* * *

A scheduled extra meeting of the Maui County Medical Society was held on Friday, February 24, 1961. Dinner was at 6:30 P.M. at Tokyo Tei followed by a scientific and business meeting at the nurses' quarters at the Central Maui Memorial Hospital.

Guests were Drs. Kenneth Haling, of the Big Island; Dr. Elizabeth Rose, of Scotland; and Dr. Russell Fraser, of England.

Dr. Fraser gave an illuminating talk in which he touched on numerous aspects of endocrinology, particularly in relation to the pituitary, thyroid, parathyroid, and adrenal glands.

CLIFFORD F. MORAN, M.D.
Secretary



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BOOK REVIEWS

(Continued from page 549)

the Wrenthan State School and the W. F. Fernald State School at Waltham, Mass.

Dr. Benda discusses mongolism thoroughly from every possible angle with sympathy and brings up to date all the available knowledge and theories of this condition. He envisions the possibility that with further research some preventive measures may become available during the development of this unfortunate condition. The reviewer enjoyed the chapter on etiology.

It was interesting to note on page 11 the statement that "many pediatricians are unable to establish the diagnosis with accuracy, often delaying a decision from 3 to 6 months." This is contrary to our experience here, where the diagnosis of mongolism is almost always made immediately after birth in the newborn nursery, where the population is predominantly Oriental.

This book is highly recommended to all physicians who must deal with mongolism in their practice.

TERUO YOSHINA, M.D.

The Psychology of Deafness

By Helmer R. Myklebust, 393 pp., $7.75, Grune & Stratton, Inc., 1960.

This book of 393 pages is up to date, and was written mainly as a textbook for advanced courses in Audiology, Language Pathology, and Special Education and Psychology.

Whether he be an otologist, general practitioner, pediatrician, social worker, or technician working with the deaf, one should find this book of great value in the psychologic problems of deafness.

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Office Diagnosis

By Paul Williamson, M.D., 470 pp., $7.50 W. B. Saunders Company, 1960.

This book covers a variety of subjects from head to foot, ailments which are generally encountered by a general practitioner in the course of medical practice. To a neophyte who is just setting up practice, it is a very good review and has many useful and valuable suggestions.

However, to a busy practitioner who has been in practice for many years, this book offers no new or bright ideas.

EDMUND L. LEE, M.D.

★Atlas of Clinical Hematology

By Katsuji Kato, Ph.D., M.D., 296 pp., $25.00, Grune & Stratton, 1960.

Dr. Kato has done an excellent job of getting this text together. The colored plates are carefully done and well duplicated by the publishers. The descriptive remark for each colored illustration is concise and simple so that this book can serve as a reference for all and need not be limited to the trained hematologist. This book should be on the shelf of all clinical laboratories doing hematological work. The author has included the unusual cells of Gaucher's disease and Niemann-Pick's disease and has described the significance of the peroxidase stain and the alkaline phosphatase activity of the leukocytes. The lack of normal and abnormal lymph node imprints keeps this book from being exhaustively complete.

NOBORU OISHI, M.D.

Also Received

Aids to Gynaecology, 12th Ed.

By W. R. Winterton, M.A., M.B., B.Ch., F.R.C.S., F.R.C.O.G., 214 pp., $3.00, The Williams & Wilkins Co., 1960.

The discussions of pruritus vulvae and leucoplakia are so very poor that the whole text is suspect.

Variations on a Theme by Sydenham—Small-pox

By P. B. Wilkinson, M.R.C.P., 74 pp., $4.25, The Williams & Wilkins Co., 1959.

Of great historical interest, with many beautiful illustrations.

The Out-patient Treatment of Schizophrenia

Edited by Samuel C. Scher, Ph.D., and Howard R. Davis, MSW, Ph.D., 246 pp., $5.75, Grune & Stratton, 1960.

For psychiatrists chiefly, this book exemplifies the new trend away from hospital therapy.

★Medical History-Taking

By Ian Stevenson, M.D., pp. 273, $6.50, Paul B. Hoeber, Inc., 1960.

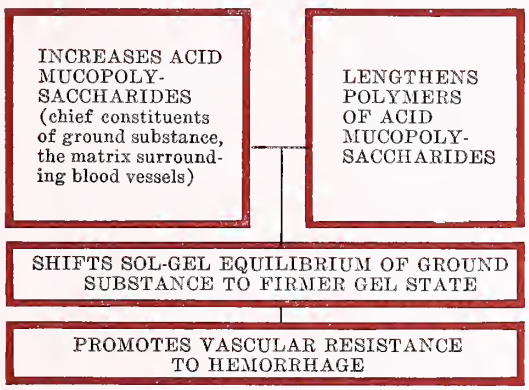
Valuable and instructive, and unhappily likely to be read least by those it could help most. A good gift for a medical student.

(Continued on page 602)

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*Schiff, M., and Burn, H. F.: A.M.A. Arch. Otolaryng. **73**:43 (Jan.) 1961.

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BOOK REVIEWS

(Continued from page 600)

★CIBA Foundation Colloquia on Endocrinology, Human Pituitary Hormones, Vol. XIII

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Cecilia M. O'Connor, B.Sc., 336 pp., $9.50, Little, Brown & Company, 1960.

International cooperation is disclosing more and more about the still mysterious master endocrine gland. LH, MSH, ICSH, FSH, TSH, ACTH, HGM, and GH are all discussed by 32 contributors.

Outline of Pathology

By John H. Manhold, Jr., D.M.D., M.A., F.A.C.D. and Theodore E. Bolden, D.D.S., M.S., Ph.D., 340 pp., $4.75, W. B. Saunders Company, 1960.

Two New Jersey pathologists have produced this concise and orderly compendium.

Importance of the Vitreous Body in Retina Surgery with Special Emphasis on Reoperations

Edited by Charles L. Schepens, M.D., 226 pp., $15.00, The C. V. Mosby Company, 1960.

Eye men will no doubt find this beautifully printed and lavishly illustrated volume of great interest and value.

The Surgery of Mitral Stenosis

By Robert P. Glover, M.D., and Julio C. Davila, M.D., 219 pp., $9.50, Grune & Stratton, 1961.

For cardiovascular surgeons, of course.

Aids to Medicine

By J. H. Bruce, M.D., M.R.C.P., 391 pp., $3.50, Bailliere, Tindall and Cox, 1960.

Pocket size, concise and inclusive. Seventh edition in half a century. Mainly for students.

Pharmacology—The Nature, Action and Use of Drugs

By Harry Beckman, M.D., 805 pp., $15.50, W. B. Saunders Company, 1961.

An undergraduate textbook, albeit a very good one. It would be a useful reference work.

Bedside Diagnosis, 5th Ed.

By Charles Seward, M.D., 479 pp., $6.00, Williams and Wilkins Company, 1960.

Differential diagnosis at the bedside, classified by primary symptoms. Not unduly detailed.

Clinical Tropical Diseases, 2d Ed.

By A. R. D. Adams and B. G. Maegraith, 540 pp., $10.50, Blackwell Scientific Publications, 1960.

A valuable reference work, brought up to date after seven years.

The Reticuloendothelial System (RES), Vol. 88, Art. 1

Edited by Otto V. St. Whitelock, 280 pp., $3.50, New York Academy of Sciences, June, 1960.

Profound.

Progress in Psychotherapy, Vol. 5

Edited by Jules H. Masserman, M.D., and J. L. Morens, M.D., 254 pp., $8.50, Grune and Stratton, 1960.

For psychotherapists. Much on psychiatry in the USSR.

Human Toxoplasmosis

Edited by J. Chr. Siim, M.D., 221 pp., $12.50, The Williams & Wilkins Co., 1960.

A 1956 international pediatric conference on toxoplasmosis is brought up to date. An excellent reference.

Automatic Clinical Analysis, Vol. 87, Art. 2

Edited by Franklin N. Furness, 342 pp., New York Academy of Sciences, July, 1960.

Of great interest to heads of laboratories, and to them alone.

A Study of Home Accidents in Aberdeen

By Lan A. G. Macqueen, M.A., M.D., D.P.H., F.R.S.H., 100 pp., $3.50, E. & S. Livingston Ltd., 1960.

An extraordinary, instructive study, of the greatest interest to anyone concerned with home accidents, their causes, or their prevention.

(Continued on page 606)

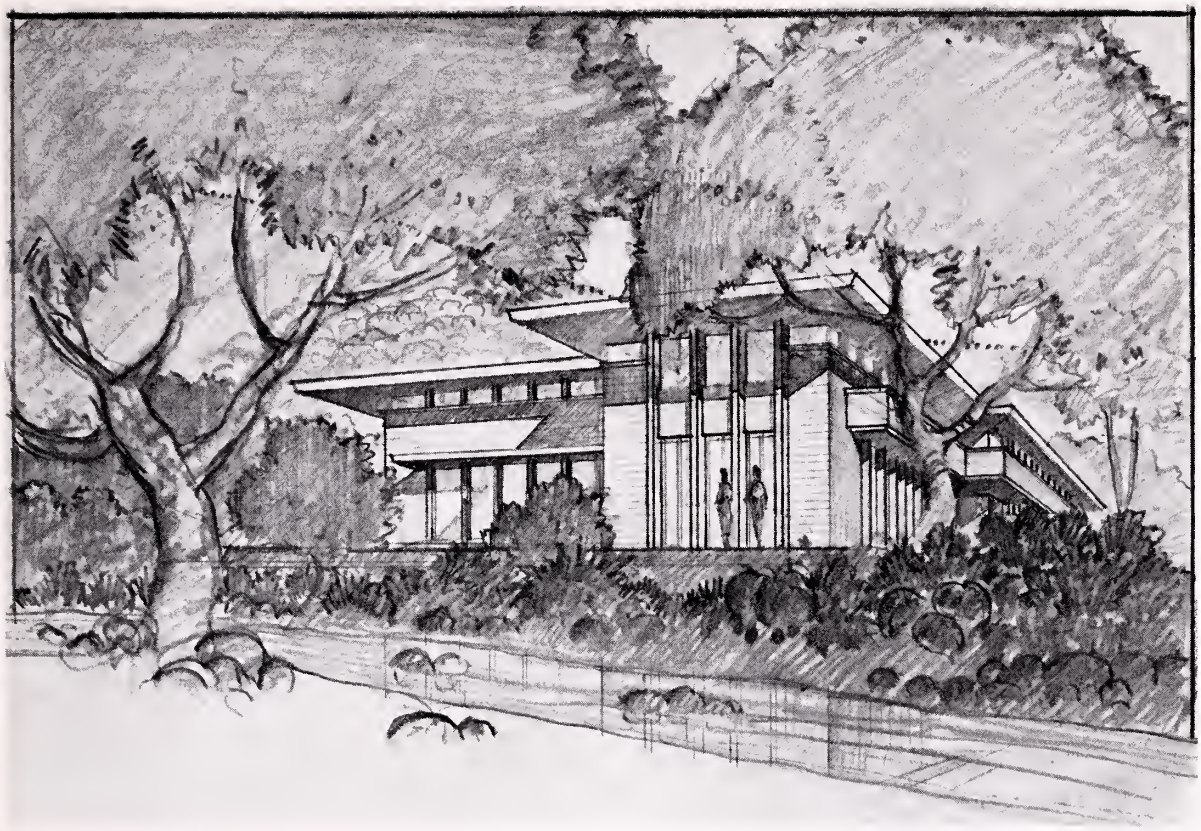
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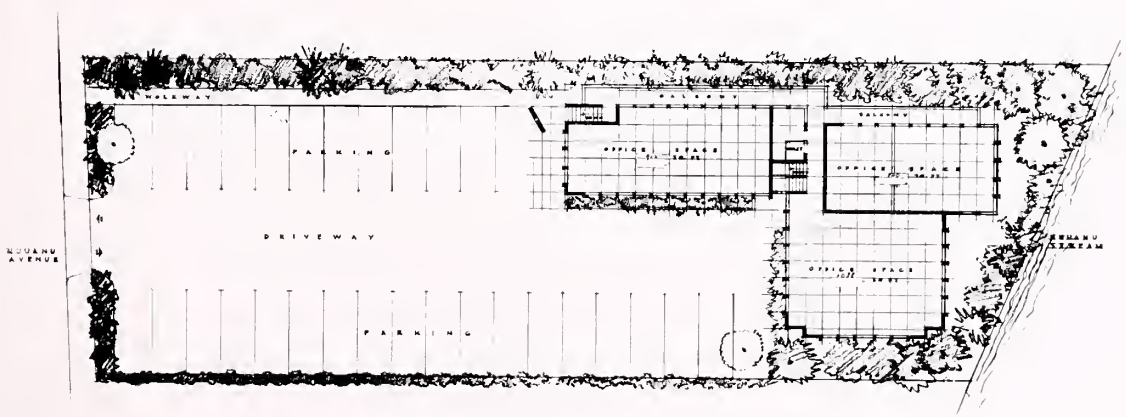
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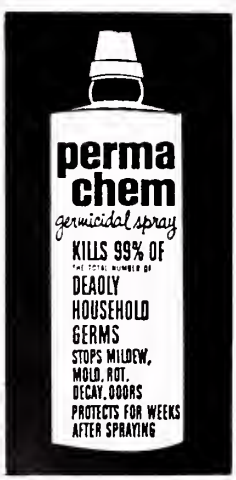
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The Journal of the American Medical Association April 4, 1959, pp. 1549-1556 printed the "EFFECTIVE SYSTEM OF BACTERICIDAL CONDITIONING FOR HOSPITALS" by Perry B. Hudson, M.D., Grant Sanger, M.D. and Edith E. Sproul, M. D., New York — from the departments of urology, pathology and surgery, Francis Delafield Hospital, Columbia-Presbyterian Medical Center.

The Medical Annals of the District of Columbia Vol. XXVIII, No. 2, February 1959 also hailed the use of perma chem.

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references: (1) Lish, P. M.; Albert, J. R.; Peters, E. L., and Allen, L. E.: Arch. internat. pharmacodyn. *129*:77-107 (Dec.) 1960. (2) Howell, C. M., Jr.: North Carolina M. J. *21*:194-195 (May) 1960. (3) Clinical Research Division, Mead Johnson & Company. (4) Wahner, H. W., and Peters, G. A.: Proc. Staff Meet. Mayo Clin. *35*:161-169 (March 30) 1960. (5) Crepea, S. B.: J. Allergy *31*:283-285 (May-June) 1960. (6) Crawford, L. V., and Grogan, F. T.: J. Tennessee M. A. *53*:307-310 (July) 1960. (7) Spoto, A. P., Jr., and Sieker, H. O.: Ann. Allergy *18*:761-764 (July) 1960. (8) Arbesman, C. E., and Ehrenreich, R.: New York J. Med. *61*:219-229 (Jan. 15) 1961.

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BOOK REVIEWS

(Continued from page 602)

Pediatric Clinics of North America, Vol. 8, No. 1

Alex J. Steigman, M.D. and Keith Hammone, M.D., Consulting Editors, 408 pp., W. B. Saunders Company, 1960.

A symposium on office practice and procedures—by 38 contributors.

The Surgical Clinics of North America, Vol. 41, No. 1

John Van Prohaska, M.D., Guest Editor, 263 pp., W. B. Saunders Company, February, 1961.

A symposium on common operations—refinements in technique—by 37 contributors.

British Medical Bulletin, Vol. 17, No. 1

A. S. Parkes, A. S. Parkes, Scientific Editor, 78 pp., Medical Department, The British Council, 1961.

A symposium on hypothermia and the effects of cold —by 16 contributors.

★Baby Talk

By Morris Val Jones, Ph.D., 96 pp., $4.50, Charles C. Thomas, 1960.

A must for pediatricians, this small volume discusses maturation in young children, with special reference to speech.

(Continued on page 608)

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★Recent Advances in Tropical Medicine

By Sir Neil Hamilton Fairley, K.B.E., A. W. Woodruff, M.D., and J. H. Walters, M.D., 480 pp., $11.00, J. A. Churchill, Ltd., 1961.

Concise, inclusive, modern, conveniently small volume. First new edition since 1929, under new management. A good book.

★Current Therapy—1961

Edited by Howard F. Conn, M.D., 806 pp., $12.50, W. B. Saunders Company, 1961.

As usual, this is an invaluable desk-top reference work. One article is by a Honolulu physician.

★ Cardio-Vascular Surgery, A Manual for Nurses

Edited by George H. Peddie, M.D., and Frances E. Brush, R.N., 170 pp., $2.75, G. P. Putnam's Sons, 1961.

Michael DeBakey wrote the foreword and says the manual will be "of immense value." 'Nuff said!

New and Nonofficial Drugs

Evaluated by the AMA Council on Drugs, 849 pp., $4.00, J. B. Lippincott Company, 1961.

An invaluable desk reference, as always. We should all own a copy!

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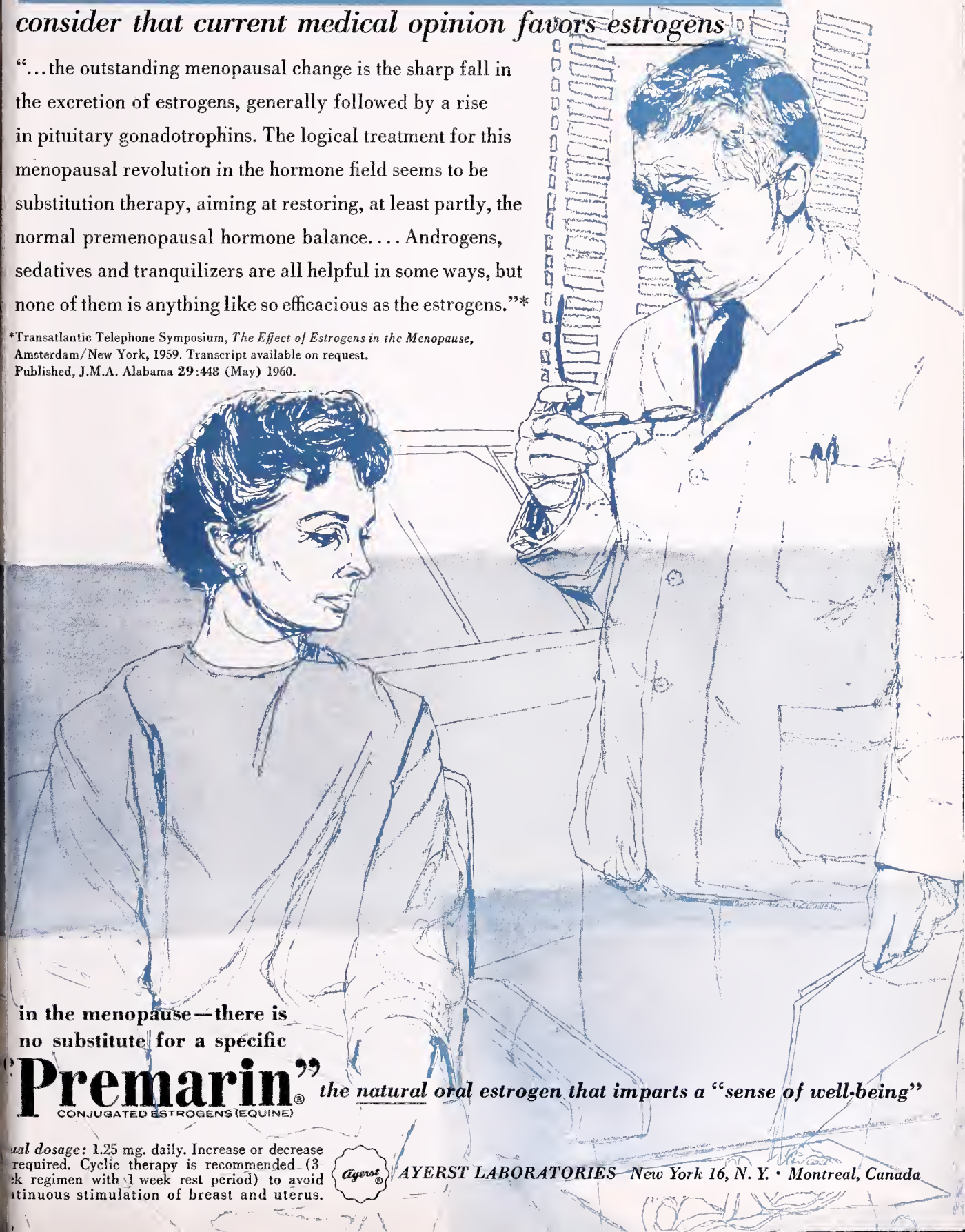
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*Transatlantic Telephone Symposium, *The Effect of Estrogens in the Menopause*, Amsterdam/New York, 1959. Transcript available on request. Published, J.M.A. Alabama **29**:448 (May) 1960.



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The Medical Clinics of North America, Vol. 45, No. 2

Irvine H. Page, M.D., Guest Editor, 267 pp., W. B. Saunders Company, March, 1961.

A symposium on hypertension and its treatment, by 28 contributors.

Importance of the Vitreous Body in Retina Survery with Special Emphasis on Reoperations

Charles L. Schepens, M.D., Editor, 226 pp., $16.00, The C. V. Mosby Co., 1960.

Verbatim reporting of the second conference of The Retina Foundation, May, 1958. There are 130 illustrations and three full color plates.

Advances in Blood Grouping

By Alexander S. Wiener, M.D., 549 pp., $11.00, Grune & Stratton, 1961.

Clearly an indispensable reference volume for the hematologist and the medicolegal specialists. "Too much about penguins" for the practicing physician.

★Textbook of Pathology

By William Boyd, M.D., 1370 pp., $18.00, Lea & Febiger, 1961.

Still the most readable textbook of pathology in the world, and one of the most authoritative, in its first new edition since 1953.

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Quality of diabetic control & Quantitation of urine-sugar

In the diagnosis of diabetes, the urine-sugar test may be little more than a screening adjuvant. But in the everyday management of diabetes, the urine-sugar test is the most practical guide we have.[1] Routine testing, however, should not only detect, but also determine the **quantity** of urine-sugar. Quantitative testing is essential for satisfactory adjustment of diet, exercise and medication. Furthermore, day-to-day control of diabetes is in the patient's hands. Quality of control is thus best assured by the urine-sugar test which permits the most accurate quantitation practicable **by the patient.**



CLINITEST® permits a high degree of practical accuracy and is very convenient.[2] Its clinically standardized sensitivity avoids trace reactions, and a standardized color chart minimizes error or indecision in reading results. CLINITEST distinguishes clearly the critical ¼%, ½%, ¾%, 1% and 2% urine-sugars. It is the only simple test that can show if the urine-sugar is over 2%.[3] Your nurse or technician will appreciate these advantages; your patient on oral hypoglycemic therapy will find them helpful. Furthermore, CLINITEST may be a vital adjunct in the management of the diabetic child or the adult with severe diabetes.

(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., et al.: Diabetes 7:398, 1958.

FOR PRACTICAL ACCURACY OF URINE-SUGAR QUANTITATION

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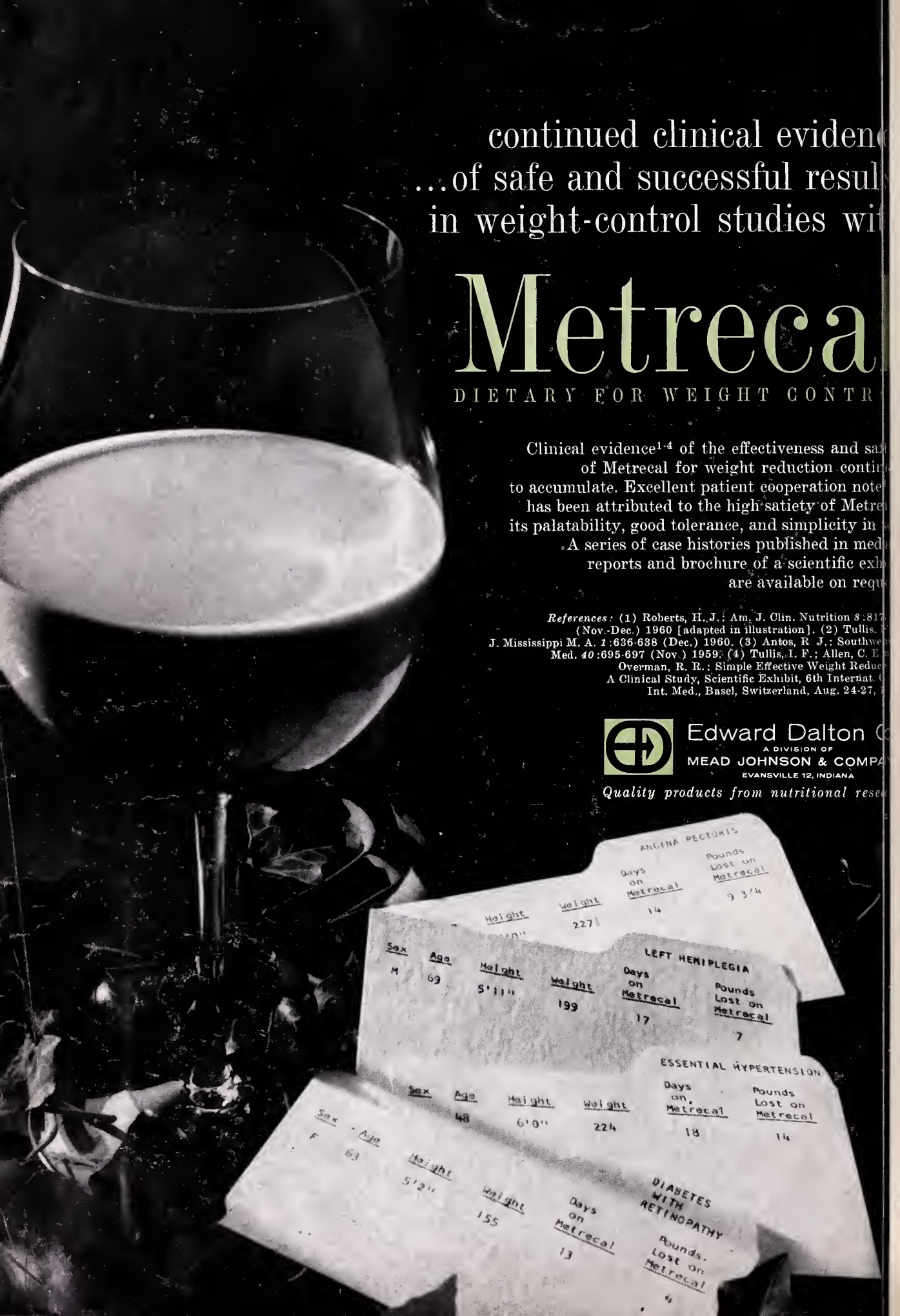
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Standardized urine-sugar test...with
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A line connecting successive urine-sugar readings reveals at a glance how well diabetics are cooperating. Each CLINITEST Set and tablet refill contains this physician-patient aid. 01561

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